REPORT RESUMES

ED 012 985 EC 000 293

ROLE OF THE COTTAGE PERSONNEL IN RESIDENTIAL CARE FACILITIES.

NATIONAL ASSN. FOR RETARDED CHILDREN, NEW YORK,N.Y

AMERICAN ASSN. ON MENTAL DEFICIENCY, WASH., D.C.

REPORT NUMBER DR-4558 PUB DATE MAY 66

EDRS PRICE MF-$0.50 HC-$4.16 104P.

DESCRIPTORS- *ATTENDANTS, *INSERVICE PROGRAMS, *MENTALLY HANDICAPPED, *ATTENDANT TRAINING, *RESIDENTIAL CARE, RESIDENTIAL CENTERS, TRAINABLE MENTALLY HANDICAPPED, EDUCABLE MENTALLY HANDICAPPED, CHILD CARE, FEDERAL AID, CUSTODIAL MENTALLY HANDICAPPED, MEDICAL SERVICES, SUPERVISORY EDUCATION, COLORADO, E R JOHNSTONE CENTER, NATIONAL INSTITUTE MENTAL HEALTH, COLUMBUS STATE SCHOOL, SOUTHERN REGIONAL EDUCATION BOARD

FOCUSING ON THE COTTAGE ATTENDANT AS AN EDUCATOR AND REHABILITATOR IN RESIDENTIAL CENTERS, THESE NINE PAPERS PRESENTED AT THE 89TH MEETING OF THE AMERICAN ASSOCIATION OF MENTAL DEFICIENCY IN JUNE 1965 DISCUSS TRAINING PROGRAMS FOR ATTENDANTS AND SUPERVISORS OF ATTENDANTS. OBJECTIVES AND TECHNIQUES FROM THE COLUMBUS STATE SCHOOL (OHIO) AND THE PINEHURST STATE SCHOOL (LOUISIANA) ARE CITED AND INTERRELATIONSHIPS BETWEEN WARD PERSONNEL AND PROFESSIONAL STAFF ARE EXAMINED. A SURVEY MADE AT THE RAINIER SCHOOL (WASHINGTON) AND THE FIRCREST SCHOOL (WASHINGTON) REPORT COUNSELOR ATTITUDES TOWARD DUTIES AND RELATIONSHIPS TO PARENTS. AVAILABLE RESOURCES FOR THE STUDY AND ESTABLISHMENT OF INSERVICE TRAINING PROGRAMS THROUGH NATIONAL INSTITUTE OF MENTAL HEALTH PROGRAMS, PROCEDURES USED FOR REVIEW OF GRANT APPLICATIONS, AND SUGGESTIONS FOR THOSE APPLYING FOR GRANTS ARE OUTLINED. THE ATTENDANT COUNSELOR TRAINING PROGRAM AT THE COLORADO STATE HOME AND TRAINING SCHOOL (WHEAT RIDGE) IS DISCUSSED IN TERMS OF GROWTH, CONTENT OF PROGRAM, AND AN EVALUATION. A 27-PAGE OUTLINE OF TOPICS AND TEACHING METHODS IS PRESENTED. EVALUATION OF THE PROGRAM WAS CONDUCTED BY MEANS OF A QUESTIONNAIRE. RATINGS OF TOPICS IN THE TRAINING PROGRAM ARE PRESENTED ALONG WITH PLANNED CHANGES. REFERENCE LISTS OR BIBLIOGRAPHIES ACCOMPANY SEVERAL OF THE ARTICLES. (CF)

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ED012985
EC 000 293

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IN
RESIDENTIAL CARE FACILITIES

NATIONAL ASSOCIATION FOR RETARDED CHILDREN
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FOREWORD

At the 89th Meeting of AAMD, held at Miami Beach, Florida, in June 1965, a series of papers were presented which focused upon the role of the attendant in residential care for the mentally retarded. Because of the caliber of content and appeal of these papers, this monograph of the papers presented in the session has been prepared.

As President of the AAMD and as President of NARC, we are concerned that only the best kind of care be provided for the residents of the institutions and we are very pleased to join our resources and make these papers available to practitioners in the field. Through meetings scheduled by the AAMD and the resources of NARC, we hope to demonstrate our joint interest and concern in this very vital area of care for the retarded.

Although this monograph is directed more toward the cottage life personnel, we are sure that administrators and chiefs of departments in institutions will find it of extreme value, particularly since the papers have been written by members of various disciplines--doctor, psychologist, educator, administrator and social worker. By the same token, we feel that parents will also find these papers to be of value to them in their understanding of what takes place in the ward and the cottages after visiting hours.

Residential care means care 24 hours a day, seven days a week. At all times, we as professionals, and as parents are concerned with making it possible for the staffs of residential facilities to do the very best possible job. The principles enunciated in these papers should provide effective guide lines to the attainment of this objective.

Ignacy I. Goldberg, President
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Mental Deficiency

Thomas A. Tucker, President
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Retarded Children

September 1965

TRAINING SUPERVISORS AS A PRELUDE TO TRAINING ATTENDANTS*

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In initiating a training program within the dormitory life area at Johnstone, several basic questions had to be answered in order to determine the appropriate method and content of instruction. The first was the global question of the responsibility of personnel in the dormitories. This consideration was very substantially influenced by the Center's mission and student population. Rehabilitation of retarded individuals and the placement of those who show capability for "productive living", in the community are specifically identified as program goals in legislative mandates and in operations which have been instituted to fulfill them (Blackman, 1961, Parnicky et al 1961, 1964). The enrollment is primarily adolescent chronologically, mildly retarded intellectually and heavily saturated with problems emotionally and behaviorally.**

Within this framework the attendant's role has some primary features. Given an ambulatory, physically capable student population, the attendant is not required to provide spoonfeeding or bedside care for the Center's students, but rather to evolve the latter's own capacity for self care, for care of his personal belongings and for care of his own room. Given an adolescent population, he is required to help the individual student develop acceptable behavior patterns by engaging him in activities in which he can expend his energies and experience personally satisfying peer and other social relationships. Given the Center's mandate, the attendant's role must contribute to helping the students gain sufficient competence to conduct himself properly and proficiently in everyday community living.

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*Based on paper presented at 1965 annual meeting of the American Association on Mental Deficiency.

**The basic program of the Center has been expanded to include two small sub-units, one for blind and one for mute retarded; a unit for rehabilitating retarded men with gross behavioral problems and another for in-patient and out-patient evaluation services are under construction.

With a substantial complement of professional personnel available at the Center, the attendant need not feel he alone carries the entire responsibility for the student's development. He can call upon a variety of practitioners to assist in modifying a student's behavior, adjustment and attitude. His efforts can be concentrated on campus aspects of the specific student group assigned him, for other workers are carrying primary responsibility for contacts with home, with community, and with employers. This admittedly is not fully realized by the entire attendant cadre.

A further consideration has been the background of attendants who are recruited for dormitory life services. Recently the State Civil Service raised the minimum educational requirements to a high school diploma, with provisions for equivalency where indicated. However, a number of attendants who were already employed do not fulfill this requirement. The starting salary level for several years has been $3,000. In July it was raised to $3,500. This has selective significance on recruitment and on in-service training. The work histories of attendants at Johnstone vary considerably. Previous experiences include parenthood, military service, industrial occupation and others. Some come early in their adult careers, some apply after retiring. Some are sole breadwinners in their homes; others are taking the job to supplement the family income. Some may hold part-time jobs elsewhere. In personality they likewise display a diversity of characteristics.

In utilizing attendants, an effort is made to capitalize on the individual capabilities, experiences and interests of attendants. For example, the three shifts to which attendats can be assigned on a weekday schedule are appreciably different. The first is from 7 a.m. through 3 p.m. Duties during these hours cover arousing students, having them dress and clean their rooms, supervising breakfast and lunch, and when most students are in school or vocational training, concentrating on housekeeping of the dormitory. Thus the attendant must be one who can work effectively both with a full dormitory as well as when it is virtually empty. The second shift is from 3 o'clock in the afternoon until 11 in the evening. During these hours the dormitory is the hub of student activity. Almost without letup the attendant is engaged in such activities as supervision of supper, recreation, bathing, snacks and preparation for bed.

The night crews come at 11 p.m. and leave at 7 a.m. They are primarily responsible for the safety of a sleeping population. If they see an awake student, it frequently means a problem. Since each shift has its demand and each has its satisfactions, attempts are made to match attendants with assignments.

Despite such efforts, there are times when attendants are called upon to do duty on more than one shift. Moreover, vacancies and promotional opportunities frequently stimulate individuals to assume new assignments. Consequently, pragmatic events have alerted administration to the importance of having all within the dormitory program well steeped in the Center's mission, philosophy and basic approaches to rehabilitation and to the attendant's roles within the program. This does not lessen the need for training for specific duties on a specific shift. The administrative staff long deliberated on the relative merits of central and unit training programs. This culminated in a basic understanding that unit supervisors have primary responsibility for preparing and enabling their employees to carry on specific assigned duties, with supplementary generic training being provided by the Center's personnel office.

Analysis of the early implementation of this policy indicated that in-service deficiencies were reduced but not eliminated. Although unit training sessions were realized throughout the Center, they were not of uniform quality, consequently not all were accomplishing the present goals. The Center's personnel officer could not possibly attend to each of the unit training efforts and provide needed assistance single handed. He was already carrying a heavy assignment of personnel duties.

When President Kennedy's program to underwrite institutional in-service training projects was announced, the Johnstone application was virtually composed and ready for mailing. Not only were problems and needs of the Center identified, but information about other institution's approaches to training had been acquired and studied. Following informal discussions of in-service programs with local administrators, the superintendent approached AAMD in 1959 and secured their cooperation in completing a national survey of their attendant staffs. This led to holding a three-day workshop in which representatives from institutions with the strongest programs, as revealed by the survey, participated (Parnicky & Ziegler, 1964, 1965). Then, in conjunction with the N. J. Division of Mental Retardation, Johnstone took part in an NIMH project which produced "A Guide for Attendant Training" (1963).

These cumulative activities reenforced the conclusion that the addition of a full-time training officer to the personnel staff was essential. The primary duties of this individual were to be conducting sessions with attendants to help them define their role within the institution, help them appreciate their part in the total rehabilitation process, and enable them to develop understandings, attitudes and skills in fulfilling their duties. The administration was convinced that the typical lecture-information approach would not accomplish the desired results. Most substantial questions about attendant's performance arise when their attitudes and outlook are not in concert with the Center's philosophy. Deficiencies in information and in skills are of a lesser order of significance. To modify attitudes, a limited but convincing series of experiments indicates that role-playing combined with discussion has potential for effecting changes in people (Culbertson, 1957; Goldberg & Hyde, 1954; Janis & King, 1954; King & Janis, 1956; Lieberman, 1956; Sause, 1954). One of the most directly related studies was conducted by McDowell, 1963.

Suffice it to say, that the training officer recruited was one who brought a background of experience in leading groups in role-playing sessions. To date he has been working with seven different groups of employees. No group includes more than 10 participants. Each is being conducted through 15 weekly meetings lasting an hour each. So far three groups have completed the series.

During the introductory session, each of the groups is given both the McDowell scale of resident-centered situations and that of job-centered situations (1963). Following this, they are conducted through weekly sessions in which a single situation is enacted by members of the group at least twice. Each enactment is followed by a discussion. The entire sessions are taped so they can be analyzed subsequently. Five of the situations are from the McDowell series and the remainder are derived from the group's own expression of interest and appraisal of needs. The following are some of the emphases in the sessions: handling of situations will differ with individual attendants and students; each form of handling has its advantages and its limitations; attitudes play an important part in the handling undertaken and results achieved. In the final session the two scales are again administered.

The group to be discussed in this paper consisted of dormitory supervisory staff. This group was the first to be enrolled because of a conviction in the importance of supervisors having firsthand knowledge of the training their subordinates are receiving, if they are to capitalize on the content which is covered. The reciprocal is the recognition that unless the supervisors are attuned to the training offered, they can do much to undercut its effectiveness. Perhaps the most germane reason for this presentation is the scant attention being given attendant supervisors in the current wave of emphasis upon attendants.

The results to be reported are based upon 7 participants in the supervisory section of the role playing series. Two levels of supervisors were included. There were three holding positions requiring college background and institutional experience. It is from this group that the Center's OD roster is drawn. When administrative offices are closed they have direct charge of overall operations on campus. The other four members fill positions which require high school graduation. All of these have had previous experience as attendants. Each is assigned a dormitory, and is responsible for operations within the building; and the condition of the individuals and facilities assigned to it. Four were male and three female. In age, the group ranged from 29 to 46. The minimum of state service was six years and the maximum 14. In three cases this service was entirely at Johnstone.

A summary of the scores obtained from this group on pre and post testing is presented graphically in Figures A - D. Inspection of the distribution of the mean scores on pre-test indicates some obviously differential patterns on the four polar dimensions McDowell selected for study. The flattest and lowest series of scores were obtained on the important-unimportant scale. Widest dispersion and highest general level are found on the easy-hard scale. The other scales are in between, with the fair-unfair scores being closely related to the important-unimportant, and the like-dislike to easy-hard.

When compared with McDowell's results, the scores of this supervisory group are highly similar. Although data provided in the former study do not permit full comparison, there is enough to confirm that basically the same patterns were secured from attendants. The comparability of results despite differences in methods of selection of subjects, in primary responsibilities of those tested, in the locations and other aspects of the institutions, require further analysis and consideration.

One possible explanation is that the resident-centered scales measure substantially basic attitudes of people regarding the incidents included, and that personnel have fundamentally the same views of the incidents. Another is that the scales may have some inherent characteristics which effect the results. For example, it is possible that the four dimensions have different sets as to which is the more favorable or expected pole. Thus, the employees tested may be more disposed to weigh the fair pole over the unfair, as compared with easy over hard. Actually we wonder if easy is the favorable pole in each incident. These suggest some of the areas which require further research.

As for relative changes which appeared after the training sessions, least changes occurred on the important-unimportant scale. Only one instance of a mean change of 1 on the 7 point scale occurred. The overall change was toward important. Greatest change occurred on the easy-hard scale. Half of the incidents were perceived on the average at least one-point away from where they were prior to the training sessions. Moreover, all these changes were toward the easy pole. On the like-dislike 5 incidents showed a change of the magnitude of one or greater. Here, however, the changes in three cases were toward like and the other two toward dislike. On the fair-unfair, 4 incidents changed one point or more, and all of these moved toward the fair end of the scale.

How do these results compare with McDowell's? Again the similarity is remarkably great. The order of change on the four scales is the same--most on easy-hard; least on important-unimportant. Again, questions must be asked. Why does this occur when the procedures of training were quite different, and the subjects met different criteria? The answers may lie in either of two directions, or some combination of them. There is the possibility that the two training efforts were comparably successful. There is also the possibility that the measures we are using predispose certain results.

Related to the latter position are the data which were obtained in the pre-test. At the start subjects in both groups were fairly convinced of the importance of the resident-centered incidents. Hence if training resulted in change, it could do so only toward the unimportant pole. If such had occurred, one might well raise question about what was offered within the intervening sessions. In a sense this is a negative check on training. The pre-training scores on the easy-hard scale had the greatest range, from a mean of 1 to that of 5.4 for the supervisory group. Hence the possibility of change here was in fact greatest. With some reservations, the shift in the group's thinking toward the easy role after training is favorable. From the extent and direction of change, it would appear that the supervisors advanced their sense of capability to handle difficult incidents. The change may, however, have been influenced by the fact that they now recognized better the favorable pole as far as the Center was concerned, and were giving more of the expected replies.

This application of training evaluation underscores that much more work needs to be done with training programs for supervisors and with techniques for judging the changes which training has initiated. In regard to the current scale, experimentation with modifications and other approaches are indicated. One inherent weakness in the existing technique is the obviousness of the preferential poles of the scales. Also, requiring four judgments sequentially on each incident probably tends to heighten the halo effect. Based on the supervisory data, and that of McDowell, it would appear that little, if any, information would be lost by reducing the technique to two scales: important-unimportant and easy-hard. A somewhat different approach would be the application of the triadic scale, where the subject is required to make choices among three situations. This, too, has its limitations, but it may dissolve some of the existing ones.

The findings based on comparing responses to the five McDowell incidents used in the training sessions with the other 15 incidents deserve at least brief comment. Even casual inspection of the graphs shows that there was no significant difference in scores obtained on the series of five as compared with the remaining 15. Applying a statistical test substantiated this. The import of this is not clear. A possible contributing factor may be the scheduling of sessions. The Johnstone course extended over four months. The content included 20 resident-centered incidents. Thus in time and content, more was included in the present study and in McDowell's. It may be that with such saturation, a more generalized impact is made upon the participants, than was evidently found by McDowell.

Operationally, what was gained through exposing the supervisors to the role-playing series? Taking the scales first, individual reactions were secured which added to the impressions obtained from other sources regarding each supervisor's attitudes and potentials. Analysis of participation in role playing, both as students and as attendants, provided another prospective of their manner of functioning.

Actually, observations during the early portion of the training raised doubts about the merits of having embarked on this program. Somewhere about a quarter of the way along, the resistance of the supervisory group became appreciable. The group became fixed on questioning why they should be involved. Did they need this? These questions were emerging not because orienting them as to the "why" and "what" of the training had been overlooked. The feelings were of sufficient intensity and substance that the designed progression was interrupted and sessions were devoted to working through the group's questions, at least to a point of resolution that permitted their resumption of the role-playing pattern. In retrospect, the visability which the training sessions provided the feelings of the supervisors may very well be a major advantage of the training procedure. If not handled, the underlying feelings would probably have had an import on how the supervisors weighed--pro or con--the training of their subordinates. Hopefully the negatives were reduced appreciably.

The supervisory series also exposed administrative problems. One was related to scheduling the training sessions. State regulations do not provide funds to pay personnel for overtime. Consequently, training time must be carved out of well-filled working hours, either by scheduling sessions during duty time, or, if after hours, by granting equivalent time off subsequently. With the supervisors, an effort was made to get the whole group together at one time. A primary advantage was having all receive the same experience at the same time. Moreover, it avoided mixing supervisors with non-supervisors. Again the feedback was strong and undodgeable. It came from those who were being asked to attend off-duty hours. Another solution had to be found to reduce the problem both for the participants and overall operations. Sessions are now scheduled at either the first or the last hour of a shift. Thus no overtime is accumulated by those regularly working these hours, and only one hour is accrued by those on the contiguous shift. Some sessions are held as late as 10 p.m. and others are being scheduled as early as 6 a.m.

To summarize, with the current wave of emphasis on training for attendants, attention given the need for training attendant supervisors may be unduly diminished. As attendant training increases, the importance of providing supervisors firsthand familiarity with the training content will grow. Results obtained from involving a supervisory group in resident-centered role playing at Johnstone indicates that appreciable gains can be realized from this approach and that additional studies focused on supervisors of attendants could be pursued profitably.

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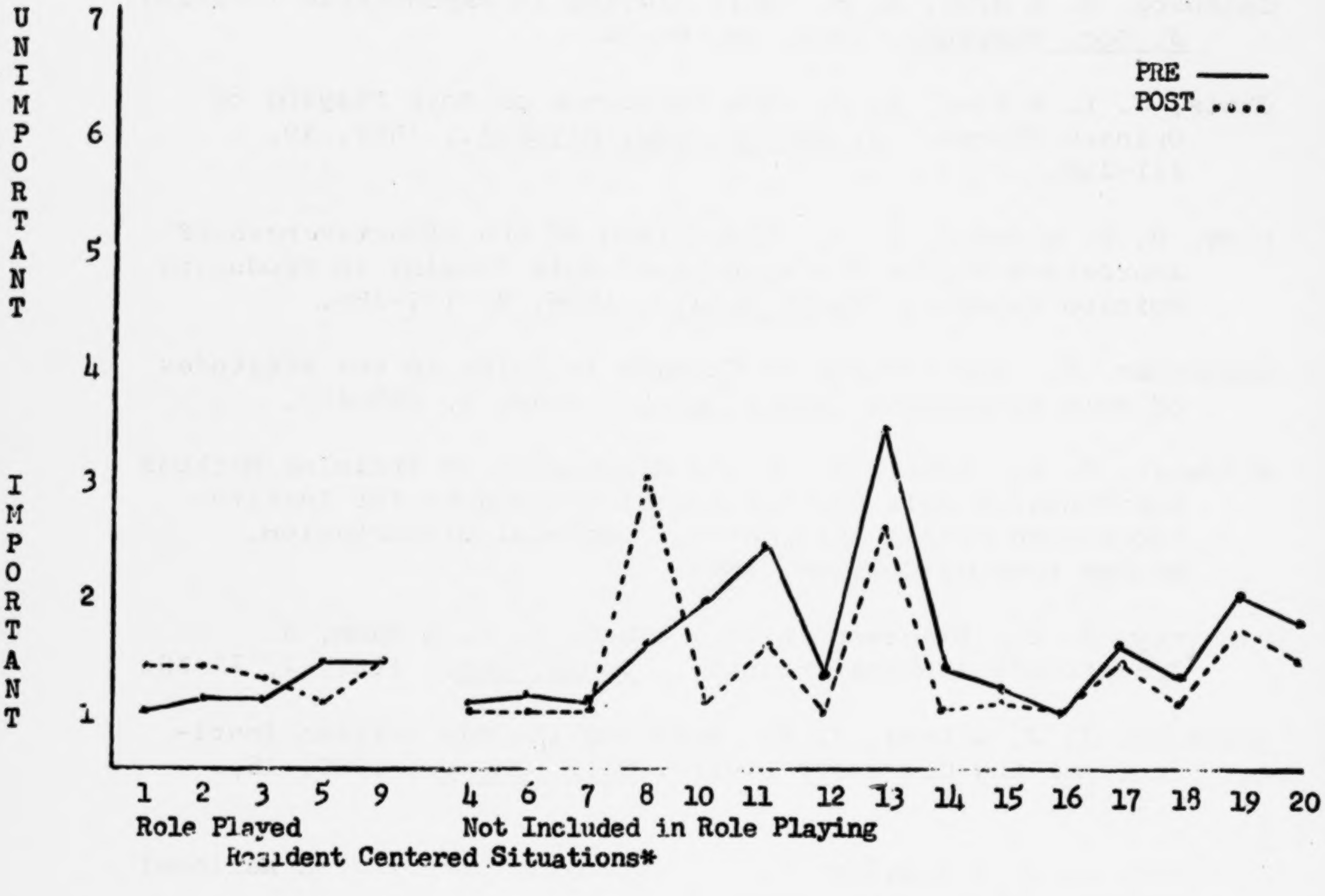
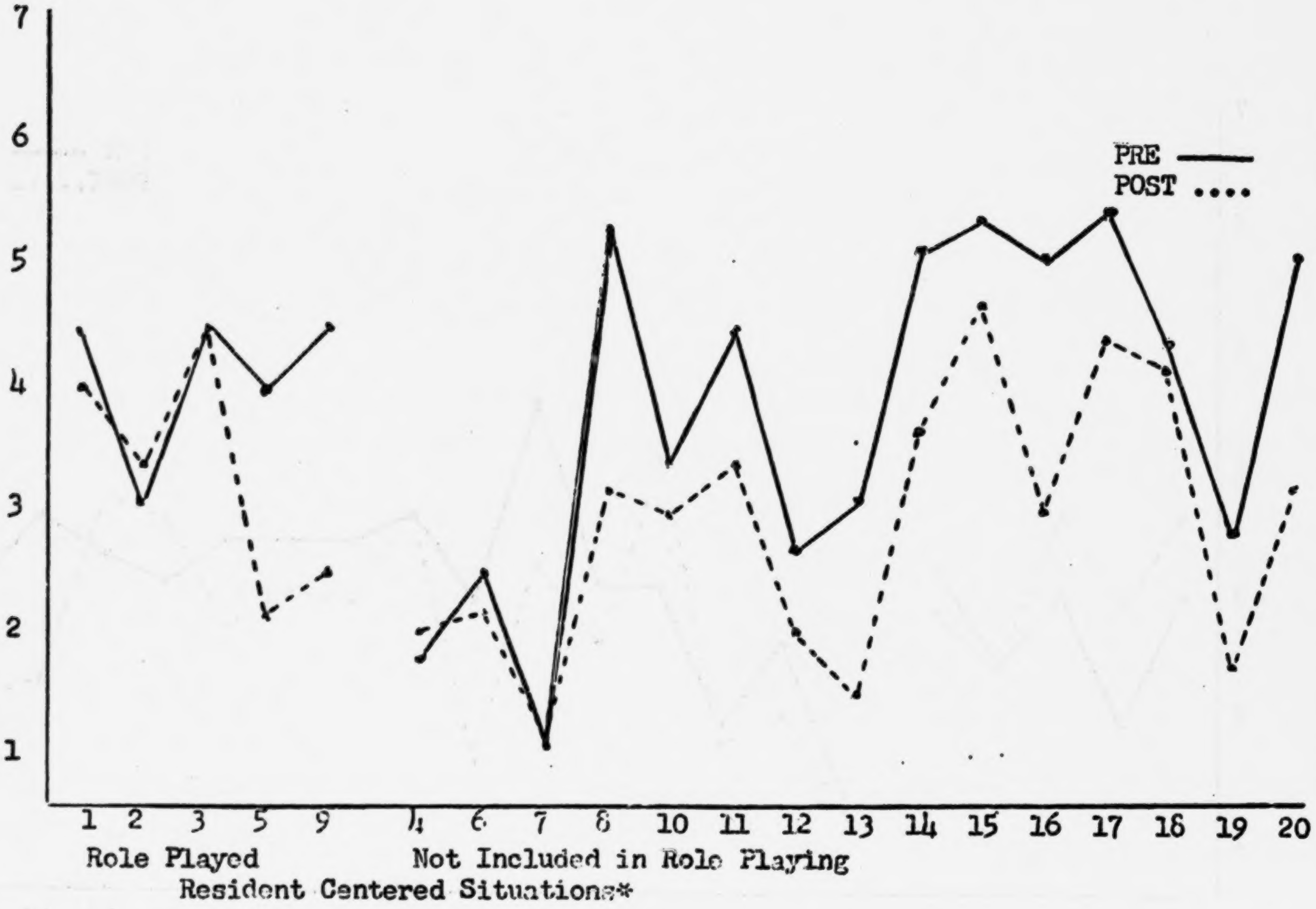
GRAPH A



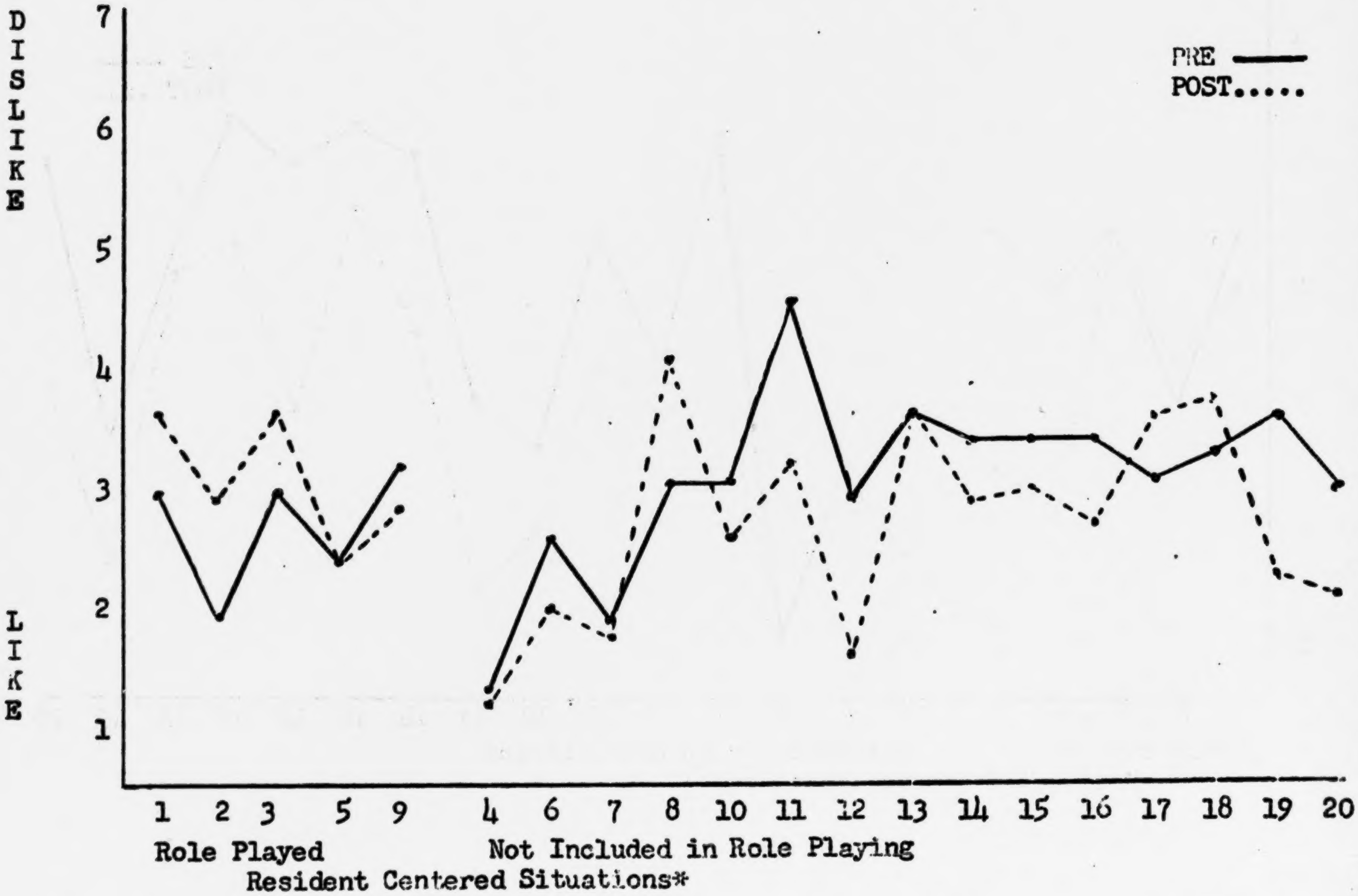
*Per McDowell, (1963)

GRAPH B



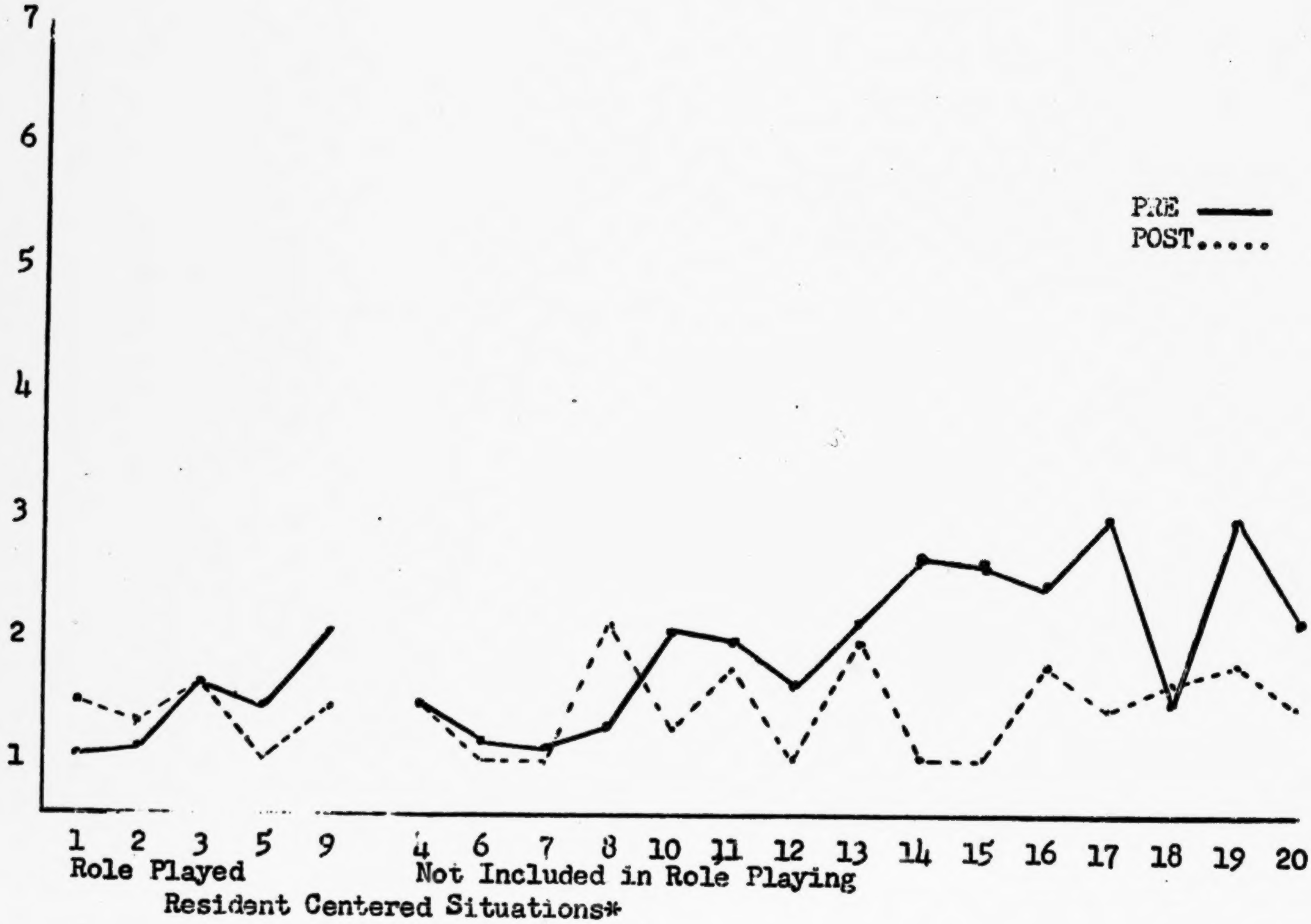
*Per McDowell, (1963)

GRAPH C



*Per McDowell, (1963)

GRAPH D



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*Per McDowell, (1963)

PREPARING THE ATTENDANT FOR HIS NEW ROLE

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During the past twenty years, there has been a dramatic shift in philosophy in our mental hospitals from that of merely providing a place of protection where the demented person could not do harm to himself or society, to the present goals of treatment and rehabilitation to enable the mental patient to return to the community as early as possible. In a similar manner, the philosophy, and consequently the program, has shifted in the various institutions for the mentally retarded. In earlier days they were regarded as custodial institutions where, at best, the goal of "keep them happy" dominated. They have turned to a dynamic approach of providing improved medical and psychiatric treatment and education and training geared to the needs of each of the residents. In addition, the emphasis is upon return to the community if the person is capable of living independently or in a semi-sheltered environment.

Only fifteen years ago, most institutions for the retarded had populations which were made up of about one-third mildly retarded, one-third moderately retarded, and one-third severely retarded. With the development and expansion of community programs in special education, sheltered workshops, and vocational training, the population in institutions is shifting so that a larger percentage fall in the moderately and severely retarded range, and patients with physical handicaps. However, this is not causing a return to the older philosophy of custodial care, but rather a continued emphasis upon training and treatment which is geared to the child's needs. Certainly, the type of training has shifted away from academic and vocational training in the case of the severely retarded. The institutions are beginning to accept the notion that the expenditure of money and the employment of additional personnel to enable the severely retarded to become independent, even in the self-care areas of walking, feeding, toilet training, and dressing, is an economical as well as humane endeavor.

In the case of the physically handicapped, this service may involve surgery or physical therapy, but in other cases it may involve a reduced patient-employee ratio to allow the staff to spend more time with the child in order to be able to teach these skills. In many cases, the child's improved condition might permit him to return to his home. However, even for the retarded child who must spend his life in the institution, this effort to teach self-care and behavioral adjustment appears justified when one considers the reduced amount of employee time required for his management.

The present day recognition of the hospital or dormitory ward as an integral part of the therapeutic environment points up the importance of ward employees in providing proper care and training for the retarded. These employees have the closest contact with the residents of the institution and, typically, are with them for the greatest number of hours each day. The professional staff person may see a resident two hours a week, but the treatment received from the attendants during the greater part of the week would be expected to have more impact on his progress or lack of progress than the treatment given by the specialist. For example, a physical therapist might spend a few hours a week with a child, but her efforts would likely be far more rewarding if there were some follow-through in exercises and encouragement given by the aides on the ward.

It was partially this philosophy which led the Southern Regional Education Board project for the development of a training program for ward personnel. The names given these personnel varies widely and have been referred to as attendants, aides, psychiatric technicians, cottage parents, orderlies, matrons, and child care workers.

In spite of the growing recognition of the importance of the cottage parent in meeting the child's physical, emotional and educational or training needs, these personnel typically come to the job with little or no training related to their job as an attendant. To make matters worse, in many institutions the salary, status and duties of the job make recruitment for emotionally stable and competent individuals difficult, and there is often a high rate of turnover in personnel. Certainly, these problems will have to be considered in any training program.

This five-year project was possible because of the interest and concern of the superintendents and staffs of the thirty-eight state residential facilities located within the Southern Region. The project was partially supported by a grant from the National Institute of Mental Health.

During the four years in which the project has been in existence, we have identified several problems and shortcomings which are associated with most training programs for ward personnel.

First of all, most instructors come to their jobs without preparation in methods of education, and they are particularly lacking in preparation for adult education. Consequently, most training programs were and are of a very didactic nature and lean heavily upon the lecture method. We teach as we were taught.

Very little attempt has been made to fit the training program to the intellectual and educational level of the trainees. For example, in a survey of thirty institutions located within the Southern region, two institutions have no minimum educational requirements, twelve require completion of the 8th grade, and four require completion of the 12th grade.

As part of a testing program associated with the SREB Attendant Training Project, some personal data was collected on a random sample of approximately fifty attendants from eleven different institutions. The mean age was found to be 40.5 years, and the mean grade completed was 9.9. Seventy-five per cent were married and 7 per cent were divorced. Similar data was collected from three institutions located outside the region, and the average age was found to be 37, or 3½ years less than in the Southern region. The average grade completed was found to be 11.5, or 1½ grades more than those from the South. A mean IQ of 92 (range 77-113) on the Otis Intelligence Test, and a Wide Range Achievement Test reading grade placement of 9.4 (range 6.1 - 17.3) was obtained on a group of 22 trainees in one of the Florida institutions.

Although the characteristics of attendants no doubt vary from one institution to another and from one geographical area to another, it si obvious that they are not the "typical students" found in high schools or colleges. Although most would fall in the normal range of intelligence, their functioning school achievement is apt to be around the 9th or 10th grade level. If the average age of attendants is between 37 and 40, it would mean that most have been out of school from 15 to 20 years. Obviously, a didactic approach to training would have little merit.

Another common fault with most training programs is the lack of integration and organization of the course. If a pattern is followed in which one instructor is responsible for most content, but others come in to teach specialized content, there is apt to be an uneveness in the difficulty level as well as repetition of material covered. I can admit, since I am a psychologist, that we are often the worst offenders in this regard because of our tendency to use technical jargon. I have heard many an instructor indicate that after a psychologist lectures, she spends the next two classes explaining what he was trying to say.

Perhaps underlying these problems of communication is the more basic difficulty of relating the training program to the job function. Many of you have heard the pat phrase which the old hands say to new trainees: "You took the class to pass the course, but I will teach you how it is really done." A nurse instructor may be teaching the trainee to take a rectal temperature for three minutes, but the nurse supervisor tells the trainee that there isn't that much time available, and to take it for only one minute.

A psychologist or educator may urge the trainees to let some of the housekeeping chores slide and to spend more time in teaching the retarded self-care skills and engaging in recreational activities. However, if the supervisors still judge the quality of their performance on the basis of the neatness of the ward and clothing rooms, it is obvious that the way in which attendants spend their time will not shift. Consequently, one often finds that the training program, in part or in its entirety, is viewed with hostility by those on the service side, because it teaches unessentials and takes the trainees off the ward, thereby placing extra work on those who remain.

All of us have been slow to admit the existence of another basic difficulty associated with attendant training. This is the fact that in many areas of attendant responsibility, we are operating on the basis of tradition and speculation, rather than experimental evidence. It is difficult enough to get agreement on the best methods of physical care and housekeeping. But to get professionals to reach concensus on how to handle problems related to emotional development and training is impossible. One is quick to open Pandora's box containing all of the arguments related to child rearing practices. It is easy for us to say to the attendant that he should accept the retarded as human beings worthy of our attention and effort and to treat them with the dignity to be accorded every man. And yet, we show by our action that we don't really mean what we say, because we place them on a ward which is in poor repair, which houses 50 retarded who are ill-fed and ill-clothed. We do not provide the attendant with enough assistance to go beyond the bare essentials of care.

Let me mention one other problem area before we turn to the more cheerful side of attendant training. This is the problem of evaluation. Does attendant training do any good? Is one method of instruction better than another? Should we train attendants to be specialists so that they can perform one job well, such as training one group to be recreation leaders, one group teachers, one group nurses aides, and one group housekeepers? Or, is it better to train all to be generalists? Unfortunately, most training programs and patterns of care and administration have not been subjected to any type of evaluation. Attendant training is an expensive proposition. One institution, for example, has four full-time instructors and provides one full year of training of each attendant. This represents an annual investment of $3,000 for each employee. And yet, they are basing their total program on "face" validity. Of course, they do give objective tests and they do get compliments from time to time regarding their program. But the fact remains that they would have a difficult time proving that all of this investment is worth while, and it would be impossible for them to defend their approach to training as being better than another method.

So much for what is wrong with attendant training ... what are the bright lights on the horizon? Perhaps the largest obstacle which has hindered evaluation efforts to date is the lack of agreement upon training objectives for the attendant. These objectives must eventually be definable in terms of positive behaviors required for the attendant. Barnett and Bensberg (1964) have suggested the development of a simulated critical incident approach to evaluation. This method attempts to bridge the gap between the classroom and the ward or dormitory setting. Briefly, this technique involves identifying many of the key situations to which the attendant must react, along with the correct methods for handling the situation. These situations can then be simulated either by actors or perhaps by film strips and the responses of the attendant scored.

Another evaluation technique which offers promise is that of making observations of the attendant as he goes about his daily tasks. If these observations are made on a random basis, it is assumed that they are representative of the way the attendant spends his total day.

By sorting these observations into meaningful categories, we could then determine the percentage of time attendants spend in activities associated with housekeeping, physical care, leisure time, etc. One way to measure the effectiveness of a training program is to note whether or not the trained attendant spends a higher percentage of time in more positive functions such as conducting recreation and teaching activities, rather than the less desirable ones such as sitting and supervising, and in leisure time activities.

Of course, one would hope that effective training programs would ultimately result in residents who were in better physical condition and who presented a higher level of social and self-care skills. A number of scales have been developed within recent years which represent an extension of the Vineland Social Maturity Scale (Cain, et al, 1963; DiNola, et al 1963.) It should also be possible to develop a physical care scale which would measure such things as skin condition, weight, etc.

All of these approaches offer promise as ways to measure change in a very complex situation filled with uncontrolled variables. However, until we do begin to isolate and identify some of these variables, we will continue to operate on faith.

Against this backdrop of evaluation, the attendant and resident are being bombarded with many novel and exciting treatments. Perhaps one of the most exciting is the approach to training by means of operant conditioning which has been applied in a number of institutions. (Bensberg, et al, 1965 and Girardeau and Spradlin, 1964). The results of such studies and demonstration projects have dramatically altered our opinion of the limitations of the retarded to learn skills, as well as the ability of the attendant to carry out the training method.

One of the side developments of these particular training programs is the mounting evidence that family groups, or group nursing, is more effective than the specialist or task-oriented approach. In the group approach, the residents on a cottage are divided into small groups. Each group is assigned to one particular attendant. With this arrangement, responsibility is easier to fix, continuity of care and training are greater, and motivation and effort on the part of the attendant are maximized.

An administrative change related to training which seems to offer promise is that of decentralization of supervision. Most of the older and larger institutions have a Department of Cottage Life, or Nursing Service which is divided into areas. Each area contains several resident buildings and each building has a supervisor for each shift. Because of the continual change of these supervisors and the area supervisors with each shift, it is difficult to maintain close supervision and to establish programs which must be consistent over a 24-hour period. Some institutions are now trying an approach in which one person is delegated the responsibility for a particular building over the 24-hour period. Special considerations are given this person to permit him to work varied hours in order to offer supervision and training to all shifts. Again, in order to maintain as much stability as possible, the personnel are not changed to other buildings, but continue to serve one particular building. Other departments work through this person in providing services to residents on that building.

The success of some of these programs suggests the obvious notion that training and supervision go hand-in-hand. Some institutions have reduced classroom teaching to a minimum and the instructors work almost entirely with building supervisors. These supervisors in turn provide most of the training.

Other institutions are trying out even more fascinating departures from the old patterns and traditions. For example, what happens when you place a group of younger retarded on a ward with older residents? What happens when you mix residents who have different degrees of retardation? Perhaps the answers to such questions will bring new ideas.

Many educators are now actively involved in preparing programmed materials to cover various parts of the attendant training curriculum. Preliminary results of at least one of these (Price, 1965) suggests that it is an effective teaching method with attendants.

At least two studies have been carried out utilizing role playing as a means of changing the attitude of the attendant toward his job and toward the retarded (McDowell, 1963, and Jansen and Stolurow, 1962). These studies suggest that this method is one way of getting more involvement on the part of trainees.

Attendants are no longer untrained and inept people who are brought off the street because they are unemployed. They have truly joined the team and help to carry out the training program so long advocated by the professional staff.

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THE ROLE OF COTTAGE AND WARD LIFE IN RESIDENTIAL FACILITIES

As Seen By An Administrator

By

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Mr. Thorne, fellow panelists, distinguished guests, ladies and gentlemen.

It certainly gives me a peculiar sense of personal satisfaction to appear on the first program on the section on Cottage and Ward Life of the American Association on Mental Deficiency. I sincerely hope your section becomes an official part of the Association.

I am a Texan by birth, a father of four healthy children by the Grace of God, a social worker by training and experience, and an Administrator or Superintendent by vocation. Currently, I am engrossed in a program of study at the doctoral level in Special Education at the University of Maryland. This self-introduction is given to either qualify me as a witness, or to excuse what I have to say. All fathers are braggarts, and a Texas father at my age with four young children is sure to be impossible. I must not start talking about things I like.

I came here today to talk to Cottage and Ward Life people about Cottage and Ward Life people. To explore their role in residential care of retardates from the viewpoint of an Administrator. I have come to talk to you about you and your job. Definitions appear in order because employees of residential facilities who are engaged in the direction of the daily lives of residents through care and training are known by many different titles. Such titles include, but are not limited to --Houseparents, Nursing Aides, Hospital Attendants, Counselors, Psychiatric Aides, etc. Please understand that whatever the term used here, it should be taken in the broad sense to include all of you.

Studies indicate that professional employees in institutions are resident centered in their concepts of their functions, while Cottage and Ward Life employees are determined to be oriented toward job and physical plants. Each of us probably sees his job different from the way others see it. Furthermore, with the demands placed on you to keep the place clean, to account for drugs, to control clothing, etc. ad infinitum--is it any wonder that you place a well-made bed and a clean cottage higher on a scale of importance of functions than does a psychologist?

Throughout the professional literature on training, emphasis is placed on the need to train Cottage and Ward Life personnel to better understand what the professionals such as psychiatrists, psychologists, social workers, educators, and others verbalize so well--where are the training programs designed to help the professionals understand better the problems, the goals, and the needs of Cottage and Ward Life staff?

Administrators get paid higher salaries because they are expected to plan, organize, staff, direct, coordinate, and do a lot of other high-sounding functions, but you may rest assured that they begin their planning with one common basic essential--staff coverage in the cottages and on the wards.

For those interested in pursuing further the studies in other literature, I have attached a bibliography. Included is information with reference to the technique of using critical incidents of interpersonal relations as a training device. Shotwell, Dingham and Tarjan, Shafter, Chandler and Coe, Jack Fleming, Harvey Stevens, and Gerard Bensberg have produced works which I recommend. These will lead you to much other information. You can gain more on your own than from any review that might be presented here.

As an Administrator, there are few things that I know absolutely, but there are many things about which I have firm convictions, and in which or in whom I have an abiding faith.

I know that I am interested in the move to create a Section on Cottage and Ward Life within the American Association on Mental Deficiency.

I am confident that I was instrumental in moving to the point where we are now. I encouraged a young Assistant Administrator who was a primary mover in pressing for recognition of you as a group. I marshaled the resources of the Institution, where we worked together, in support of the plan.

Last year when the proposal to establish a Section was presented at the Kansas City meeting, objections were raised on the basis that the other sections were composed of professionals and were so identified as Medicine, Social Work, Education, Psychology, and Administration. The argument used against this objection was simply that membership in the Section on Administration was based on position occupied without reference to competence in or identity with any profession. By far the largest number of employees who work with the mentally retarded in institutions are those in Cottage and Ward Life. You are perhaps the only group who work full-time with residents. Why, then, should there not be a Section within the AAMD for you?

I know that experience has demonstrated many times over that the most essential employees are those in Cottage and Ward Life. When new cottages or even new institutions are planned, they are always started with a basic coverage on the wards and in the cottages. Board members, legislators, and others concerned understand and accept the need, although they never supply you in sufficient numbers. It is when we ask for more social workers, recreation specialists, clerks, and others who do spend all of their time in direct care of residents that assistance is met. Even when additional maintenance personnel is requested, one hears such responses as--a new building won't need painting for awhile, new machinery shouldn't break down, but no one says there is no need for staff to care for residents.

During times of manpower shortages, such as wartime, adjustments are made to assign those who are available to Cottage and Ward Life. We may still need psychological workups on residents, we would like to have other special services, but we must have coverage in the cottages and on the wards. You are essential!

May we look briefly at some of the reasons?

When an Administrator decides to use a building on the grounds for a different purpose, sometimes you are in on the plans and know why, but most of the times the reasons are not clear, and all the advantages accrue to other than Cottage and Ward Life. For instance, actual living space for residents may become office space for part-time workers. Even if the change is to your advantage, you are the ones who must bring the residents to give up the old and help them adjust to the new. These are areas in which experts agree retardates have their most difficulty. Furthermore, you are probably expected to pack supplies and equipment and help move the furniture.

When the coordinator of volunteers comes up with a large number of tickets to the circus or plans some other trip of interest, who must select the children to go and dress them properly? Who must plan for those who cannot go and deal with their disappointments? Who has to think of plans for meals? Who has to accompany and control residents on the trips? Who is it that must care for the exhausted upon the return or try to quiet those who have become over-stimulated? You do, of course, and in addition it is quite likely that you will be expected to drive a bus on the trip. Should you dare mention the break in routine housekeeping for the cottage, you immediately are labeled as being oriented toward the material things. You are job centered rather than interested in residents.

When the dentist prescribes braces that require rubber bands, who is expected to put on fresh bands, daily, at the risk of losing a finger or two? You are, because this is hardly a technician's work, and normally a mother would do so in the home.

When a social worker plans a home visit as therapy for a disturbed child, who must be completely understanding while trying to help the child again adjust to cottage routine? Who is told in no uncertain terms she is criticizing a professional technique she does not understand if she dares say it might be a problem to overcome damage done by an over-indulgent mother. Yet, it is obvious that the mother cannot handle the child in the first place, else there would never have been an admission or commitment to your care as the case may be.

When the medical officer finds several cases of impacted bowels among the cottage of adult, trainable females, who is blamed for letting them refuse to eat vegetables and other roughage? The staff on the wards, naturally. Should the doctor prescribe suppositories and laxatives, who must administer the treatment and worry with residents up all night complaining of cramps in the mid-section? Who has to do the spot mopping, bed changing, and bathing for those who don't quite make it to the toilet? You do, because your job calls for care and training of residents. Would you dare say it to the Administrator even if you knew some of the residents who received the suppositories and laxatives were not impacted? If you did, would you learn anything more than not to question a doctor's orders.

You see, I know you do most of the work in direct service to the residents. What I have listed above might indicate that you only respond to situations planned by others, but I also know that many wholesome, interesting, beneficial activities and on-going programs are conceived, implemented, and evaluated by you.

I know you should be eligible for membership in the AAMD, and have your own Section.

I am supremely confident, with the abiding faith of which I spoke, that your Section will be officially approved, and will make and outstanding and worthwhile contribution to the field in general, and to the American Association on Mental Deficiency, in particular.

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THE ROLE OF COTTAGE AND WARD LIFE IN RESIDENTIAL FACILITIES
Psychologist's Point of View

Social Habilitation-Striving and Training Toward Independent Living Skills

by

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(Paper presented at annual meeting of AAMD
Miami Beach, Florida, June 9, 1965)

The Cottage Life Department at Pinecrest State School in Louisiana supervises 23 residence units or cottages which are homes for over 1,200 residents. The Medical Department supervises an additional ten areas which house 700 residents.

These 33 units all differ in the category of mental retarded they house and serve. There may be as few as 25 or as many as 100 retardates living in any one cottage at Pinecrest.

The Cottage Life Department's primary purpose is to govern the residents' daily living activities in such a way as to most nearly approximate home conditions. In every cottage, both in the Medical and Cottage Life Department, a program is designed to make the children as independent in areas of self-help as possible.

It is in this area of striving and training toward independent living skills that I would like to share with you, both from a theoretical and practical viewpoint, some ideas as well as some successful experiences.

Historically, the role of cottage and ward life in residential facilities was that of custodial care. Custodial care usually meant feeding, toileting, bathing, and caring for the mentally retarded--or "doing for" the retarded even among the higher level educable retardates. We then moved into a period of educating the educable and training the trainable and still providing custodial care for the profoundly retarded or the untrainable. Throughout this historical development, we find evidences of rebels who implemented training procedures to meet the individual needs of each retarded child. Most recently, Dr. Norman Ellis (1963) challenged psychologists to put away their binet kits and to utilize knowledges gained from research in learning to institute programs for training the retarded for development of independent living skills. Dr. Ellis contends that too much emphasis has been placed upon diagnosis and care of the retarded with the result that training has been neglected. Furthermore, where training has been utilized there has been less emphasis on care.

Attempts to train the retarded in the development of independent living skills have been primarily guided by the principle that the mentally retarded individuals at all levels have difficulty in learning the abstract and that training should begin with the concrete. Using this guiding principle in almost every institution, as well as in every community, we send our retarded to "school" programs to learn self-help training skills; and these retarded do learn these skills at schools. However, it appears that we have failed to ask ourselves if independent living skills, developed in "school" programs, necessarily enable the retarded individual to use these skills in the cottage or the home. Whether or not we have asked ourselves this question, we have apparently made the assumption that the retarded individual can transfer self-help skills from the "school" to the cottage or the home, when we continue to train the retardate in the school and not in the cottage where the skills will be utilized.

From the standpoint of experimental evidence, there is very little to support or refute such an assumption. Very little is known about generalization behavior in retardates, and much less is known about the source of observable behavior differences among retardates; that is to say, behavioral differences which may be attributable to environmental variables and conditions of learning which facilitate or interfere with transfer or generalization in retardates (Rosenberg, 1963). Knowledge or data about the sources of observable differences in retardates is needed to provide an empirical base for educational and training programs.

Such knowledge that is available concerning generalization or transfer behavior indicates that training and education should be done under those conditions which best simulate those conditions where human performance is to be typically observed.

In this respect, the role of cottage and ward life at every level of mental retardation needs to be geared to a definitive program of self-help--independent skills on the cottage where the skills will be utilized.

Recently, our Director of Cottage Life at Pinecrest, Mr. Cecil Colwell, told me that two years ago, his major concern was that of providing adequate care on the cottage, but now his concern is in the area of program development; and his experiences have demonstrated to him that a definitive program of training will result in improved independent living skills as well as adequate care.

I would like to briefly describe some programs that have been implemented.

Utilizing the training design suggested by Ellis for toilet training the profoundly retarded, one study (Dayan) found that the profoundly retarded would and could be trained to be retentive in toilet activities and defecate appropriately when placed on a commode by utilizing a food reward. By simply placing soilers on the commode on routine time schedules, more than 90% of the soiling "accidents" were eliminated. This study found that some profoundly retarded, IQ's below 20, could be trained to approach the commode utilizing rewards.

At another institution, a pilot project of training the profoundly retarded was implemented using a mass stimulation approach. The mass stimulation served as a reward. A profoundly retarded youngster, who previously was only bottle fed, was trained to feed himself with a spoon; another girl was toilet trained and trained sufficiently enough in self-help skills that it was possible to transfer her to a higher level cottage. It should be noted that when the mass stimulation was removed, there was regression noted among some of the subjects toward their older behavior patterns. The regression behavior might be explained theoretically as the result of "cue" change.

Pinecrest State School implemented a behavior shaping program for the profoundly retarded. The program has been documented by film as well as by monthly ratings. These films, photographed at Pinehurst State School (1965), are available for viewing. The program implemented, utilized shaping behavior with positive reward procedures outlined by the Brelouds. Six profoundly retarded were placed on a training cottage and an attempt was made to improve their self-help behavior by the techniques of behavior shaping. Monthly ratings were made on a modified form of the Vineland Social Maturity Scale. All subjects showed substantial improvement. The greatest gain was obtained during the first month of conditioning (Bensberg, Colwell, and Cassel) (1965).

After approximately eight months of training, the subjects were returned to their cottages because of administrative expediency. It was hypothesized that some regression would be noted as a result of the change; a slight regression was noted. Subsequently, a training program was implemented for the entire cottage. The residents were divided into four training groups. Within four months, all subjects showed a substantial improvement.

Pinecrest has recently received a HIP grant to expand this program to additional cottages. The program will train cottage parents in behavior shaping techniques and compare behavior shaping training with the usual "mothering care" procedures.

Some of these experiences in training the mentally retarded tend to substantiate the point made earlier. Namely, that training and education of the retarded should be done under those conditions which best stimulate those conditions where the mentally retarded typically function--in the ward and in the cottage.

These experiences in training the mentally retarded also tend tend to indicate that retardates have difficulty in generalizing. For example, we trained a youngster to put on his shoes, but it was then discovered that if we changed the color or type of shoes, he had to be retrained. The profoundly retarded, when given speech training by a speech therapist, improve in the speech therapy area, but regress to the old speech patterns back on the cottage.

I have used these examples of training the profoundly retarded in three different institutions to demonstrate the changing role of cottage life and have provided a few explanations for the change. In all three of these institutions, the cottage parent was no longer mopping soil and urine, changing diapers, and feeding youngsters. The cottage parent's role became that of a trainer or teacher. After training was initiated, there was no soil to mop, no diapers to change or children to assist in eating.

If the role of cottage life thus can become that of a training cottage even among the profoundly retarded, or as previously believed, untrainable cottages, then what might be the role of cottage life in the higher level cottage?

Through intensive on-going in-service training programs, cottage parents can be taught to be parents and trainers rather than "attendants".

I would like to briefly share with you some areas of training, other than usual feeding, toileting, and dressing skills, that can utilize behavior shaping with positive rewards.

Discipline. Ellis (1963) described the effects of reward and punishment on the retardate's behavior in an institutional setting. He suggests that every institution and cottage life department is typically the disciplinarian and thus should have a system of rewards and punishment. The rewards must be given for the desired behavior, that is, the behavior which contributes to the person's own well being and the community in which he lives. For example, Pinecrest has been very successful in their pay incentive plan (Cassel-1964). There is some evidence, at least, for higher level retardates that self-government might well be more effective than our first thoughts might lead us to believe. Edgerton and Dingman (1964) report some favorable consequences of unsupervised "dating" within an institution. They were: (1) improved control over time and space, (2) ability to employ techniques of subtle communication, (3) understanding and internationalization of the rules for conduct, and (4) control of sexual impulse. Thus we see, by rewarding the retardate with freedom, this permits him to learn the essential requirements for social living.

Reading. For the educable youngsters, the "cues" or the opportunity for reading should become available to the cottage. The cottage parent should provide reading material and rewards for reading and appropriate reading experiences on the cottage to best facilitate reading ability.

Communication. For all levels of retardation, the crucial individual in the development of communication skills is probably the mother image. Within the institution, this is the cottage parent. A speech therapist within an institution might consider the most adequate utilization of his skills to improve the communication teaching skills or techniques of cottage parents and teach cottage parents to develop communication among their residents by using appropriate scheduling of positive rewards.

Visual-Motor. The development of all higher level academic skills is dependent upon the development of visual-motor skills. (Hephart). I would suggest that the physical therapist and physical education teacher might better utilize their time by training cottage parents the techniques of motor development using behavior shaping techniques.

Self-Help and Independent Living Skills. I have discussed earlier in some detail certain training programs for the profoundly retarded. I predict for the future, that for higher level residents a greater number of actual experiences in work situations, more half-way houses for residents than are presently in existence, which will reflect a greater emphasis on independent living with training playing an ever growing part in cottage life.

In summary, from the psychologist's point of view, the role of cottage and ward life should become one of training and not care. Through in-service training, we can develop the concept that learning and any behavior, good or bad, is learned behavior, usually brought about through some definitive program of cautiously scheduled positive rewards.

The new role of cottage and ward life in residential facilities is probably best expressed in the words of the musical, South Pacific, "You have to be carefully taught."

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THE ROLE OF COTTAGE AND WARD LIFE IN RESIDENTIAL FACILITIES

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Relationship of Education Departments with Cottage and Ward Life.

The central role of the day-by-day care of the residents in a residential school rests with the attendant or psychiatric aide personnel. While not professionally trained for these positions, the present system of in-service training supplements the parent substitute role. Warm understanding, coupled with knowledges and skills on child care and development are essential aids in working with children assigned to living units.

The Department of Education should maintain a very close relationship with living units and their personnel. These personnel, with orientation, are able to supplement and cooperate with the teachers in planning and executing educational techniques and procedures. Attendants are usually extremely interested in the educational program planned for their residents.

One of the means by which the living unit personnel work with the Education and Training Department at Columbus State School is by membership on "Teams." These teams are composed of the unit physician, unit matron and a psychiatric aide, a psychologist, unit social worker, unit recreation worker and a representative from the Education and Training Department (usually a supervisor).

The team has for its primary purpose the consideration of a resident's total program--problems which may arise in day-by-day living; his home relationships; his recreational, school and job programs. They check to see if all previous recommendations have been implemented and review the results of such implementation and activity. Each member of the team discusses the child, his strengths and weaknesses as he has seen him in a particular setting. In many instances the child is personally interviewed by the team as a whole in order to better understand his viewpoint on some of his problems or wishes. Such discussion and personal interview make possible a unified approach which in my thinking can not be done as effectively in any other way.

Teaching the principles of good grooming and personal hygiene (such as care of teeth, hair, use of deodorants, care of clothing) is emphasized in every area of the school program. As an example, boys who are scheduled to the Home Economics Program are permitted to bring their clothes to the Home Economics Classroom and wash and iron them. They are taught the proper washing procedures and how best to iron their shirts and other clothing. Girls are taught the proper use of cosmetics, how to apply them and how much. Together with the more common home economics teachings they add how best to care for their clothing. Smaller children are taught how to keep their fastenings closed, how to care for their hair and comb and brush it, and how to brush their teeth. The residents under the guidance of the attendant are able to practice these things taught in the school, thereby giving them added meaning. Thus, learning is a two-way street achieved through the cooperation of the living unit and the school.

Incidentally, television advertising may be doing much of the best teaching for both boys and girls in this area. The use of athletes for commercials and the introduction of the romantic element may be more appealing and lead to better understanding by many youngsters than classroom instruction.

In schools where many off ground trips, work assignments, social affairs, etc., are a part of the program, the aid of the living unit personnel is of paramount importance in helping residents to select and wear the proper clothing for the right occasion. The young men who assist in our Audio Visual Program showed the films and filmstrips used at our last Regional AAMD Meeting. From their appearance it would have been hard to identify them from any other youngster.

The unit works with all other media, including the school, in developing responsibility, cooperation, courtesy, honesty, reliability--those attitudes necessary for living and working with peers, adults and authority figures. Among the many aspects which can be included under this area is the teaching of proper conduct when attending public places off grounds both in groups and singly. It includes the teaching of how to use the public transportation facilities and action while using them. It also includes the proper attire and conduct when going off grounds to select clothing. Our institution has set up charge accounts at several local stores which are used by residents and attendants when purchasing clothing for the residents' use. Through weekly trips to the commissary, with the attendant or by himself, the resident reinforces his academic learning of arithmetic by actually using money to make his purchases.

The use of the pass system, issued when the resident has proven his responsibility, permits the resident to go and come to school and other appointments unaccompanied. This freedom of movement develops responsibility, promptness, and awareness of time, which the teacher aids in developing. It also helps the unit keep a reasonable check on the amount of movement involved with a resident.

One of the areas in which many of our younger children are deficient is in intelligible speech. There are many ways that the attendants can augment the speech therapy done in the classroom or in individual instruction. They can label and name toys, objects or actions as the child uses them. They should not accept gestures if the child can verbalize and should encourage an accepting attitude toward the child who has a speech problem--try to eliminate teasing. The attendant should speak in short and simple sentences to children with limited language ability. With older children who have articulation problems the attendant could spend a few minutes listening to key words which the child is working on in speech class. The attendant should attempt to listen when a child does have something to say, giving the child the appropriate response. They should also praise or encourage the child for noticeable improvement in speech and this encourages him to try even harder. An attendant can also talk to children with no language as though they could hear and understand because very often they can. This serves as a language pattern and a stimulant. For children who are deaf and who may not learn a great deal of language, the attendant should send a list of necessary words to the speech therapist and in that way aid her in teaching him words needed for self-sufficiency. They can also, through the team, refer children for speech therapy or speech and hearing testing.

All children, whether retarded or not, may need some form of discipline for varied infractions of regulations. In cases of this kind, the school and unit cooperate in providing some form of restriction; the removal from an activity which provides pleasure and happiness; or in some way is a source of personal satisfaction to the resident (such as watching T.V.). It is highly important that the discipline be administered at the time of the infraction and that the resident understand the reason for the discipline.

In most instances residents should not be permanently removed from participation in a school program because of conduct, language or misbehavior. However, in some cases this must be done to protect property or the well being of other youngsters in the school program. Infractions of school regulations may result in restriction from school and other activities for a very limited time. The unit personnel are willing to work with the school administration and staff in such matters and their reaction within the unit is not in the least punitive.

One of the responsibilities shared by the school and unit is helping the child to understand himself. It is desirable that as far as possible he learns what his limitations are and hoe he can best compensate for these in daily living. When each individual is able to develop a concept of himself he is better able to consciously deal with problems of daily living, understanding of his peers and respect for authority. Motivation, reward, persuasion, use of special interest to make learning more attractive--all can be factors used by the unit and school to help the resident develop security and confidence.

Probably no one factor is more important in the development of the retardate than that of his self-concept.

At the Columbus State School there are many instances when the direct relationship between the school and unit has proven most helpful. For example:

> Special assistance rendered by the units in getting children to and from school events;
>
> Reporting to the unit the seizures which occur in school so that medical records can be kept up-to-date;
>
> Requests from the school for special beauty parlor or haircut appointments when needed in order that a resident be especially well-groomed for some event;
>
> Requests for residents to come to school at scheduled times for special practices and calls from the unit for children to be returned for doctor's appointments, dental appointments, and shopping trips;
>
> Requests from school to unit for medical check-ups to determine fitness of resident to participate in some type of school activity--such as physical education; and
>
> The sharing of information between the unit and the school in relation to changes in a child's behavior.

With these factors well formulated and implemented, the school and living unit can achieve an excellent working arrangement which is mutually advantageous.

In closing I am using a quotation from Gareth Thorne's new book, "Understanding the Retarded."

> "Most attendants do not often think of themselves as teachers, and of course, they are not teachers in the formal sense of the word. However, they are teachers to the degree that they extend their influence to the children in their charge so that these children learn ways of facing and adjusting to problems of life, ranging from the meeting of basic needs to the more complex task of adjusting to a variety of perople and situations. Perhaps the greatest educational gift that the attendant can bestow is the image of himself. The resident imitates the behavior and actions of the attendant. Good habits of adjustment and living are learned this way as well as bad habits. In the institutional setting, there is little excuse for not keeping a good example always before the residents. One of the main things to remember when working with the retarded is that they are great imitators. Attendants, therefore, need to exercise special caution so that residents are exposed to situations which will benefit them in their learning to adjust to the world about them, not only now, but in the future as well."

In my experience it is equally important for the teacher as well as the attendant to serve as an example and add to those desirable experiences learned by the resident from living unit personnel.

THE ROLE OF COTTAGE AND WARD LIFE IN RESIDENTIAL FACILITIES

FROM A MEDICAL VIEWPOINT

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Presented on Friday, June 11, 1965 at the 2-4 P.M. Session on "The Role of Cottage and Ward Life in Residential Facilities" at the AAMD Annual Meeting, Miami Beach, Florida

Today with our appreciation of the shortage of skilled personnel, we are trying to use the professional at more appropriate times and as a teacher of the non-professional. We have been surprised at what the non-professional can do when given orientation and direction of this type. As such, this Panel's presentation is particularly significant not withstanding the fact that we are here today not for the above reasons but because of our increased appreciation of the need to look at cottage and ward life personnel and their roles as a critical part of improving residential care programs.

The role of cottage and ward life in a residential facility can be approached from the point of view of "What can cottage and ward life staff do to help insure the best of medical services to the patient" as well as to help provide good medical care efficiently and in such a manner as to avoid the institution's excessive expenditure of resources, both personnel and financial, in this area. There is much that the cottage and ward life can do regarding this facet of institutional life for the resident. I would like to suggest that one administrative problem today is that we create dependency of our staff as well as of our patients by not appreciating their true value and various abilities, thus expecting little from them. They have two major functions. One is that of an observer and reporter and the other is that of an implementer. Let us take the second role first as it can be described very quickly.

First, this role is not less important than the role of observer and reporter, but it does take less skill. In this role the cottage and ward life staff merely follows the physicians orders and recommended procedures in the manner they have been previously taught. The leeway they are permitted will vary from state to state and from institution to institution. In some institutions, they will be permitted to do very little in this area as most procedures of this nature may be handled by the nursing staff. In others, they may give simple medications, carry out simple procedures such as wet and dry dressings, enemas, proper positioning of the motor handicapped or bed patients, or even medications other than by injection. These are examples and not a list of possible treatments. In addition, cottage and ward life staff may be trained to carry out simple physical therapy exercise such as range of motion exercises, gait training, and most would probably be allowed to use appliances such as splints, braces, standing tables, relaxing chairs under varying degrees of supervision.

On the other hand, the role of the observer and reporter is more complex and perhaps of greater value to the patient at the residential facility. This is especially true if the facility is small and does not have full time medical coverage.

It has long been known that routine medical examinations are of limited value and can only identify those medical conditions far enough in advance which present some manifestation that can be found by laboratory tests or physical examination. These techniques are usually not predictive but determine the status of the individual only at the time that they are performed. It has been known that a person can pass all tests well and have a heart attack an hour later. This is an extreme example, but one which occurs. School health examinations have been reduced in many areas to only a few during the school period rather than one every year because of the little value of this type of screening determination in relation to the other needs of medical services. In the State of New York, teachers were taught indications for possible health problems and pupils were referred to health facilities by teachers only when they found these cues. Results revealed that these referrals had a high degree of positive medical conditions.[1] The implications should be quite obvious. Instead of wasting our supply of medical personnel, our medical personnel could be used to a greater advantage at more pertinent times in relation to the residents medical needs. The additional use of annual surveys for tuberculosis, urinary conditions, anomalies of the blood system would have great value.

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[1] Culbert, Robert W., M. D., F.A.P.H.A.; Jacobziner, Harold, M.D., F.A.P.H.A.; and Ollstein, Philip, M. D., F.A.P.H.A., Training Programs in School Health Service, American Journal of Public Health, Vol. 44, No. 2, February 1954, pp. 228-234.

The attendant can very easily identify those patients with nutritional and/or feeding changes, mood and emotional changes, skin conditions, lumps or growths, changes in gait, increase or decrease of coordination, major problems of vision or hearing, just as parents can identify these factors in their children. Parents become attuned to regular patterns of their children and any change should indicate the need to search for a reason. The cottage life or ward attendant should and does get to know their charges in the same way. Since many of the patients cannot express themselves well, if at all, much of the change in a patient must be picked up by observing their reaction or behavior. Speaking as a pediatrician, I find this to be no problem as any mother usually learns to do much of this before her baby is one to two months old. As a matter of fact, I feel that young patients can tell you what is wrong more directly than the adult who modifies his story to suit himself, confuses it with his wishes or emotional state and communicates frequently his story in a distorted fashion to the physician. I would much rather work with children since they are so much more direct in their reactions generally.

Furthermore, we have found at Plymouth that by early reporting and prompt medical attention for the patient's medical needs during the day, especially in the morning, that our physicians receive very few calls at night. As a matter of fact, we receive fewer night calls with 800 patients and 8 physicians than we did with 340 patients with two physicians.

Early detection of medical conditions also means less disability to patients, short duration of illness and probably less residual. All these factors help reduce the set-backs of progress which can occur so easily to the institutionalized resident.

Another major aspect of medical care in institutions relates to seizure control. In many institutions, only major seizures are reported. However, there are many minor types, some of which result in abnormal behavior without gross abnormal motor activity and loss of consciousness. These seizures can also interfere with a patient's functioning and can cause additional emotional disturbances when not recognized. Proper identification and treatment of this condition enables those working with the patient to do a better job since a seizure is diagnosed best by observation and history. Again, the role of the cottage life personnel is obvious and helpful.

Another very important observation is the feedback of the cottage life personnel on drug or treatment reactions so that the medical personnel can adjust the treatment program accordingly. Although we have good guides for dosages, such guides are very general, especially with the young child or when certain medications are used on patients with organic brain damage syndromes. Some drugs enhance the effect on one another and the patient may become too sedated. Lack of coordination may be on this basis rather than on the organic changes. Some tranquilizers can aggravate seizures. Even with treatments and appliances there is a need for feedback. Patients can become overtired or develop other abnormalities of gait or posture from appliances that do not fit properly or are used too long, especially when first begun. Changes in growth require changes in both dosage and modification of appliances. Again, these have to be tailored to the needs of the patient and cannot be stereotypes. Feedback from the cottage life staff will assure the resident of timely adjustment of the treatment program which perhaps should not wait until the patient's next clinic visit.

The examples discussed are by no means the entire gamut of conditions in which cottage life or ward personnel can be valueable in the medical aspects of patient care. However, they do point out several important areas of relationship and provide each of us with examples which can be used as a starting point for such relationship of other medical activities with cottage life and ward personnel. Much of medical diagnosis is based upon history and much of treatment is modified or finally adjusted based upon individual reaction. Without these important items of information, the physician is severly handicapped in his care of the patient. Since residential patients do not have available parents to help, it becomes the duty of cottage life and ward staff to provide satisfactory substitutes for the parental role in these cases. Through specially tailored training programs for ward and cottage life personnel, this should be done and can be done if we so wish it.

THE ROLE OF WARD AND COTTAGE PERSONNEL

by

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May 1965

PHILOSOPHY AND EXAMINATION OF CHILD CARE CONCEPTS

The planning of services for the care of children who, for various reasons, have been removed from their own homes has traditionally and historically been the concern of the Social Work profession.

From a study of the historical developments of the 19th century, we are cognizant of the rapid growth of public welfare programs and the extension of services to those in need. Of basic concern in a democratic society are the needs of children and for the development of services to provide for their care and protection. The dedicated work of Social Workers such as Grace and Edith Abbott, Julia Lathrop and others resulted in the creation of both private and public agencies devoted to programs of child welfare and child care. The evidence is prevalent in modern western society that in the development of welfare services and in the allocation of local, state and federal budgets, the needs of children have a high priority.

Each child is a unique individual. Each child has common basic needs which must be met if his physical, emotional, social and intellectual development is to take place. Children must feel wanted. They must feel convinced that their parents love them, care what happens to them and not just tolerate them. They must feel and understand that they provide their parents and others with joy and satisfaction just by their very existence, even though in periods of growth and development the problems they create often appear intolerable and unsurmountable.

Provided with a supportive, understanding network of interpersonal relationships and experiences, children form a self-image which assumes vital importance for character development, mental and social adjustment in the developing and adult years.

It has been well-documented and now an accepted concept that the removal of a child from his own home, especially in his early years, creates serious damage to his self-image and to his ability to continue to develop and form meaningful relationships.

The work of Anna Freud, John Bowlby, Bruno Fettlebein and others who explored and studied the effect of separation of the child from normal parent-child relations in his own home, contributed to the knowledge which provided for the creation of the small group-caring home, group-treatment centers, the foster home system and adoptive services. Within these particular or specialized living institutions it was expected that a therapeutic milieu would develop which would enable the child to re-experience and re-identify with positive relationships. Unfortunately the adaptation of these child-caring concepts and services were not, and still have not been accepted or actively promoted on behalf of the mentally handicapped child.

While paradoxically society has provided agencies and services to meet the individual needs of the deprived, the abandoned, the emotionally disturbed and the delinquent child, the type and quality of care provided for the mentally handicapped has been to deny the above mentioned basic child-care concepts by herding the mentally retarded children into large impersonal institutions where, in the main, they are subjected to routine and often impersonal care taking place in overcrowded halls.

CHILD CARE RESPONSIBILITIES IN INSTITUTIONS

Most of the large institutions were designed for mass care. The modern institution should provide group care based upon the individual needs of every child within the group.

The scientific searchlight having more recently been focussed on the characteristics of the mentally retarded, a high ratio of professionally trained staff has been induced to seek employment in institutions. The recent emphasis on state and federal planning and the availability of federal funds to supplement institutional budgets is affording the means to strengthen weak aspects of programs and to initiate services long denied retarded individuals in residence.

Emerging from custodial concepts of child care to include individual programs of education, training and habilitation, we are now recognizing, more forcefully, that the hall or ward is an integral part of the therapeutic environment.

As programs are being developed to improve resident care, training and habilitation, the role of the ward and cottage personnel must assume an importance not previously conceived.

A study of the available literature indicates that there is a growing interest on the part of the administrations of many institutions to develop in-service training programs for hall personnel. There is also evidence that the influx of professionals into residential treatment and life has complicated the responsibilities of the hall personnel and created considerable confusion about their role. Some authors point out that the attendants are threatened by lack of formal education and modest socio-economic background. Others mention that the attendant staff have difficulty in accepting or carrying out recommended procedures because they contrast these with their own experience in child rearing.

Every institutional staff member knows that it is the hall staff who have the 24 hourly care of the children, who are with them and about them in their daily lives, watching them "lick their wounds", listening to their heartaches and sharing their joys and achievements. These are the people who are responsible for every aspect of the daily activities of the children. It therefore follows that the success of each child's program depends to a great extent upon the skill, ability and devotion of the attendant staff and the recognition which each staff member has of his own role and function.

Most of the moderately and mildly retarded children entering institutions today have their own parents available. For them, institutional training is a phase in their development after which return home is often possible. There are also large numbers of children in institutions at this time whose parents have grown weary with this care and concern and literally deserted them. For all of these children, in various degrees of intensity, the institutions must arrange substitute family living and it is the attendant staff who provide the closest approximation of a parent figure.

There are, of course, certain basic difficulties which interfere with these staff members assuming full responsibility for this role. They must train the child, treat him with understanding and love and discipline him when necessary. In this role they are often criticized or threatened by the child's natural parents and clinical staff members. They do not have parental rights or responsibilities. They are salaried employees, they work an eight hour shift and must accept that someone else takes over where they left off. They often know very little about the child and are responsible, not for one or two children, but for large groups of children. Often, when they have developed a relationship with a child, he is removed from their care and they may not have been included in the decision. Even in the most advanced programs, continuity of relationships between the attendant staff and the child is difficult to achieve. Yet all who work with children, and particularly Social Workers, subscribe to the concept that the continuity of a positive parental relationship is essential in contributing to the growth and adjustment of children.

INTRODUCTION TO STUDY

In preparation for this paper, while it was necessary to examine social work concepts of child care in institutions in the light of current developments, I felt that it would also be helpful, and perhaps enlightening, to pursue with the attendant staff, how they themselves conceived of their role and function.

With the assistance of several staff at Rainier School, and particularly Dr. V. M. Tye, Chief of the Psychology Department, an opinion survey was developed and sent to attendant staff chosen at random who were employed at the Rainier School, Buckley, and the Fircrest School, Seattle, in the State of Washington.

Rainier School accepts moderately and mildly retarded children and young adults to a capacity of 1,725, residing on 20 halls, with a staff complement of 600 plus. The School was awarded a Hospital Improvement Project grant which permitted the administration to reorganize the school's program into smaller, more easily managed units, each housing a homogeneous group of residents. Clinical teams were assigned to each unit to develop individual child and general hall programs. The particular focus of the philosophy of the program at the School is to develop each individual to reach his maximum of habilitative functioning. The general goal is to return as many residents as possible to community employment or community based living situations.

An In-Service Training program for attendant staff supported by a training grant from the Department of Health, Education and Welfare, has been in operation for one year. The goals of the training program are "to improve the quality of care and services given to the resident, to increase the understanding and acceptance of the philosophy and policy of the

School, to improve attitudes, improve staff morale and to lessen the gulf in knowledge and understanding between professional and non-professional staff."

Fircrest School accepts the very young and older severely retarded and physically handicapped children and adults to a capacity of 1,000 with a staff complement of 440. The Hospital Improvement Project grant awarded to the School is designed to "assist the parents of children whose names are on the waiting list, through counselling and demonstration sessions, to develop more adequate care for the child and by deeper understanding of his needs to keep him in his own home and community as long as possible". The School also places many of the older retardates, with intellectual capacities to borderline, into community nursing home care, thus exposing them to small group living advantages in local communities.

Fircrest School developed an In-Service Training Orientation program in 1962. The overall aim of the training program is "to develop a Counselor who will become a therapeutic person in the field of retardation" through attitude development, specific knowledge and its application, and skill and training in behavioral development and physical care procedure.

STUDY DESCRIPTION

The survey was sent to Attendant Counselors working on eleven halls, or wings, at each school.

At Rainier School, 66 forms were sent, with 52 being returned--a 15% participation of the Attendant Counselors employed, and included 36 female and 16 male employees.

At Fircrest School, 36 forms were sent, 35 were returned with 12% participation, and included 27 female and 8 male employees.

The survey was sent to Attendants on the morning and afternoon shifts including grades I to IV (grade IV being the Hall Charge). The Personnel Board specifications define the work for grades I and II as "trains and cares for mentally retarded children in institutions". For the grades III and IV, the definition reads "supervises and participates in care and treatment of mentally retarded children". The minimum qualification for grades I and II being completion of eighth grade of school, experience in practical nursing or child care may be substituted, year for year, for education. For the grade III and IV, completion of eighth grade of school and two years of experience or training in caring for mentally retarded.

Ten Attendant Counselors at the two schools are members of AAMD although the majority would have heard about the and attended local meetings. The Study Questionnaire was therefore prefaced with the explanation that the Council of AAMD was to be petitioned to create s sub-section on Cottage and Ward Life within the general section of AAMD.

The hypotheses on which the study was based were:

1. That the Attendant Counselors are confused and unsure of their role and function;

2. That the definition of their duties, salary and working conditions have denied them a position status and failed to provide them with and group organization; and

3. That the classification Attendant Counselor does not define the role expected of them in modern child programs of training and habilitation.

The questionnaire was divided into five sections to provide information about the following: their reasons for taking the job; the duties of their job; the problems and difficulties of their job. They were asked to name with whom they consulted about difficult problems on the hall; should parents visit more on the halls; should parents volunteer their services on the hall where their child lives; and to suggest changes for the name "Attendant Counselor".

The study findings were extremely revealing, providing material which appears to substantiate, in many ways, the above mentioned hypotheses.

It is also suggested that the study provides a basis and suggests a real need for a more extensive research project such as on a regional basis of AAMD.

DISCUSSION OF THE STUDY FINDINGS

1. Examination of the reasons for taking the job:

The Rainier School replies indicated that the two largest groupings, a combined total of 38 (73.1%) women and 11 (21.2%) men "liked working with children and people" but who also "needed extra income".

The Fircrest School replies, a combined total of the two largest groupings, 26 (74.3%) staff - 19 (54.2%) women and 7 (20.0%) men "liked working with children and people" and were also "interested in the mental retardation programs".

Conclusions: While the Fircrest School replies suggested a higher motive than income, the high percentage of women working in this field, the age and physical needs of the men, the lack of formal education and training of both men and women suggests the need for extra income and the availability of this type of work are probable factors in the acceptance of the work.

2. Duties of the job:

This section was grouped into five divisions. The computations were tabulated to provide an average percentage of time spent on an average day in the following:

a. Caring for the physical needs of children--such as dressing, feeding, toileting:

b. Working with children--such as teaching children to dress, to feed themselves, to make choices;

c. Developing relationships with children--such as talking with them, spending time alone with them, listening to their problems;

d. Institutional services--such as attendance at meetings, housekeeping, training sessions;

e. Contacts with parents--such as talking with parents about the child and the hall program, etc.

The study findings indicate that the women staff at Rainier School spend 53.8% of their day in duties which involve them in physical contacts with the children, i.e. caring for physical needs and working with the children, while the male staff spend 78.1% of their time in similar activities.

Institutional services occupy another 19% of the female staff time with 9% of male staff time. Twenty per cent (20.0%) of both female and male staff time is spent in developing relationships with children, and contacts with parents involve the staff in 6.5% and 4.8% female and male respectively.

The Fircrest School findings indicate that 60% female time and 68% male time is spent in physical contacts with the residents. Institutional services occupy 16% and 15% female and male respectively, while developing relationships with children involves 19% and 14% and contacts with parents 5% and 3% of their time.

Conclusions: The results of this question suggest that the Attendant Counselors are performing the duties required by the Personnel Board specifications of their job. They appear unable to see or to use acts of physical care and the training of children as the means whereby they could establish relationships with them to contribute to the child's emotional and social growth and to fulfill their role as a substitute parent figure.

3. The problems and difficulties of the job:

The answers to this question were many and varied. The results of the question indicated that the staff at both schools have similar problems.

Insufficient help was listed by both schools as the major problem. Rainier School returns--39 (75%) and Fircrest School--28 (80%). The next large groupings: too many changes at Rainier School--13 (25%); and at Fircrest School, developing the child's potentials or teaching skills to the child--12 (34.3%). Both schools noted lack of communication listed by 10 (19.2%) staff at Rainier School and 11 (31.4%) staff at Fircrest School. Over-crowding was listed by 10 (19.22) Rainier School staff but not noted by Fircrest staff. Four (7.7%) staff at Rainier School noted "not enough freedom to use their own judgment" as to problem.

Conclusions: The results of this question highlights administrative and supervisory concerns. The problems of insufficient help, over-crowding, lack of equipment reflects political and budgetary concerns facing state institutions. The gulf between the professional and Attendant Counselor staff also creates some problems.

4. When you have a problem on the hall, from whom do you get the most helpful answer:

The answers to this question revealed strong identification with their own supervisors and senior members of their group.

At Rainier School, 21 (40.4%) listed the Supervisor; 22 (42.3%) mentioned the "house parent" who would be the Charge IV person on the hall. Note the significance of the use of this term.

At the Fircrest School, 21 (66%) listed the Supervisor or Wing Charge. At both schools clinical staff help was mentioned by 5 (10%) at Rainier School and 4 (11%) at Fircrest School.

Conclusions: The results of this question reveal some insecurity of the hall staff that results in their not consulting with other available resources at the school. However, a significant portion of staffidentify with the concepts of a mother figure and therefore indicate that they are aware of the need of the role of a substitute parent in the lives of the children.

5. Should parents be encouraged to visit the hall:

The results of the question "should parents be encouraged to come to the hall, more or less, announced or unannounced", was strongly positive at both schools.

Rainier School joint response was 85% in favor of more visits. Fircrest School joint response was 86%. The staff at both schools were equally agreed that parents should be announced when visiting, although 15% of the staff at both schools could accept unannounced visits.

6. Should parents volunteer on their child's hall:

At Rainier School 21 (58%) female staff and 12 (75%) male staff responded that parents should be encouraged to volunteer services on the hall where their own child lived. Answering no to this question were 13 (36%) female and 4 (25%) male staff.

Fircrest School replies indicated 17 (63%) female and 5 (62.5%) male staff were in favor of parents volunteering on their child's hall. Answering no to this question were 10 (37%) females and 3 (37.5%) male staff members.

Duties with which the parents could help were listed as ironing, mending, feeding, recreation, field trips and helping to train their child.

Reasons as to why parents should not work on the hall where their child lived were: other children would feel neglected, it would create favoritism and partiality.

7. Comments on name classification of Attendant Counselor:

Lastly, the participants were asked to comment on the name classification Attendant Counselor.

At Rainier School, 26 (54%) preferred this name; 10 (20%) did not reply; 7 (13.5%) preferred some form of Counselor such as Child, Youth or Remotivation Counselor.

Fircrest School staff indicated 22 (63%) had no preference; 9 (26%) suggested House or Cottage Parents; 4 (11%) were interested in the name Child Care Counselor.

Conclusion: These replies reflect the feeling of lack of status and inability to choose a name which defines their conception of their role. It is interesting to note from the results mentioned above that 22 (42.3%) identified the "House Parent" as being most helpful to them with problems yet the majority of participants were unable to conceive of themselves as "House Parents".

SUMMARY AND CONCLUSIONS

The paper has discussed social work concepts of child care and the difficulties which confront the ward and cottage life staff in defining their role and function in institutions for the mentally retarded.

The petition to be submitted to the Council to create a Sub-Section on Cottage and Ward Life within the general section of AAMD appears timely and necessary.

The results of the above study, though confined to two institutions and while no doubt reflecting local conditions, suggests that such a section under AAMD would provide cottage and ward staff with the following:

1. Clarification of role objectives and duties as a result of their contacts with others in similar work.
2. Identification with the group which would bring increased status, improved conditions of work and salaries.
3. Training opportunities and association contacts which would improve the quality of services provided for the children.
4. Broader recruitment incentives particularly to younger men and women who would be attracted by higher salaries and status position.

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THE INSERVICE TRAINING PROGRAM OF THE NATIONAL INSTITUTE OF MENTAL HEALTH*

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Inservice training represents the newest dimension among the many efforts of the National Institute of Mental Health to improve the mental health manpower of the Nation. Earlier and continuing efforts include support for training every physician in psychiatry and mental health and increasing the supply of well trained psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, and related professional and research personnel needed in the mental health field. Support has also been extended to the development of new teaching and training methods and to special training programs in the mental health aspects of mental retardation, juvenile delinquency, geriatrics, and alcoholism where there are serious shortages of trained personnel. All of these efforts are essential to the mission of the Public Health Service to improve health personnel standards and health services to the people of this country.

The long-range objectives of the inservice training program of the National Institute of Mental Health are to work through the Department of Health, Education, and Welfare Regional Offices with State mental health agencies to increase on a continuing basis the effectiveness of available staff in hospitals for the mentally ill, training schools for the mentally retarded, and other community mental health centered agencies and services, and to translate rapidly increasing knowledge into more effective services to people, by means of job-related training.

This program, which began in 1962, is administered by the Inservice Training Section of the Training and Manpower Resources Branch of the Institute and was planned in two phases: (1) to help ready States to plan for inservice training programs; and (2) to help States implement their inservice program plans.

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*Prepared for presentation at the Eighty-Ninth Annual Meeting of the American Association on Mental Deficiency, June 10, 1965, Miami Beach, Florida.

I would like now to highlight the principle steps undertaken in these two phases to develop the inservice training program of the Institute on a continuing, long-term, programmatic basis rather than in a project or time-limited fashion.

Phase I

Phase I, which began in 1962, was, and continues to be, an effort to prepare States for an expansion of their inservice training plans and programs. Principal activities undertaken in this readiness phase of the program include:

A. Regional Conferences

With the very active participation of the Mental Health Consultants in the DHEW Regional Offices and over 130 individuals from State mental health agencies and universities serving on advisory committees, seven regional conferences on planning State inservice training programs were held during October, November, and December 1963. The objectives of these conferences were:

1. To examine current thinking and practice in the areas of inservice training broadly defined to include all personnel employed in State and community mental health service programs;
2. To determine the nature and extent of training activities in State mental health agencies;
3. To explore ways of expanding training efforts and means by which the State mental health agencies, colleges and universities, and the NIMH can work together in developing more adequate training programs in the States;
4. To help each State develop an adequate conceptual model for its State mental health training program.

Following these regional conferences, intended primarily for State-level personnel, most participating States held similar conferences for personnel in their mental institutions and other facilities. Many States have since included inservice training in their State mental health program plans and provided State-level staff with responsibility for assisting State mental institutions and community mental health facilities in the development of their inservice training programs.

B. Staff Training Visits

Beginning in January 1963, funds were made available through all DHEW Regional Offices to enable personnel in State and local mental health programs with major responsibilities, especially for inservice training, to (1) observe and study at first hand the most effective available examples of inservice training in other States and the manner in which they are programmed and administered; and (2) to participate in conferences, seminars and special courses as will increase their effectiveness in planning and carrying out their programs.

C. Development of Inservice Training Resources

In cooperation with the Pilot and Special Grants Section of the Training and Manpower Resources Branch, inservice training projects have been started which we hope will further importantly the development of inservice training both nationally and on a regional basis, e.g., (1) the development and demonstration of a core curriculum for houseparents and home supervisors in residential child treatment facilities; (2) the production of films for use in inservice training programs; (3) training teachers to deal with hyperactive emotionally disturbed children; (4) short-term training in mental health data processing for State mental health agency statisticisms; and (5) training psychiatric aides in social milieu therapy for chronic schizophrenics.

D. Recent Studies Relating to Inservice Training Program

As part of the Mental Health Manpower Studies Program of TMRB a national survey of professional personnel in institutions and clinics for the mentally ill and retarded has been completed, and a study of psychiatric aides published. These studies will help State agencies and institutions in the development of their inservice training programs not only for aides and attendants, but other personnel such as aide trainers, supervisors, and those in positions of professional and administrative responsibility. Still other studies important to inservice training are being planned by the Manpower Studies Unit.

Phase II.

As you may know, the first funds allocated for inservice training, per se, became available in September 1963. A total of $3,304,000 was made available for grant support of inservice training in fiscal year 1964.

In recognition of the fact that personnel such as psychiatric aides, attendants, houseparents, and others similarly involved in direct patient care constitutes an important treatment resource in mental hospitals and institutions for the mentally retarded, the first major area of support was extended primarily to this general category of personnel. Grant support for inservice training has since been broadened to include all personnel, sub-professional, technical, and professional, with direct responsibilities for patient care--in addition to, not in lieu of, training aide and attendant personnel. And efforts are continuing to broaden support for training eventually all employees in mental hospitals, institutions for the mentally retarded, and community mental health centers.

Of the 433 State institutions eligible for these grants, 298 or 69 per cent are mental hospitals and 135 or 31 per cent are institutions for the mentally retarded. With assistance from Regional Mental Health Consultants and responsible State mental health agency personnel, over 250 of the 433 eligible institutions have applied in the last two years for inservice training grants totaling some $7,500,000. Awards for the grant period beginning July 1, 1965, have been made to 226 institutions, and of these 143 or 64 per cent were made to mental hospitals totaling $3,225,000, or 64 per cent of the funds awarded; and 83 or 36 per cent were made to institutions for the mentally retarded for a total of $1,850,000 or 36 per cent of the funds awarded.

Information from grantee institutions indicate that despite an all but impossible time schedule, shortages of qualified instructor personnel, low salaries allowable under State merit systems, and many other such hurdles, surprising progress has been made in initiating and improving inservice training programs. This has been possible for a variety of reasons, such as, strong administrative support for inservice training from the responsible State mental health agencies and from the grantee institutions; transfer of present staff to the inservice training program with provisions for upgrading such instructor personnel; use of consultants and other training resources in other State agencies and local organizations, including universities and colleges.

The Institute staff in the Training and Manpower Resources Branch and in the DHEW Regional Offices stand ready to join with staff from the responsible State agencies to provide information, consultation, and other assistance to all institutions eligible and interested to make application for grant support for inservice training. A Special Announcement, "Training Grant Support for Inservice Training of Mental Health Personnel," has been mailed by the Mental Health Sections in the DHEW Regional Offices to all eligible institutions which have not as yet been awarded grants. As this announcement indicates, application kits are available from the Regional Office upon request from any eligible institution interested in applying for a new or supplemental grant. The deadline for receipt of applications is August 1.

Now for a few words about how inservice training grant applications are reviewed. Like all training and research grant applications submitted to NIMH, inservice training grant applications receive a double review--first, by our sub-committee on Inservice Training in January, and by the National Advisory Mental Health Council in March. Notices of grant awards are mailed in late April or early May, and payments are made in June for expenditures beginning July 1. It is anticipated that some $7 million will be available for inservice training grants in fiscal year 1966, compared with $5 million awarded in fiscal year 1965, and over $3 million awarded in the previous year.

In considering inservice training grant applications on a merit basis, there is no fixed check list of criteria. Rather, consideration is given to the appropriateness of a given proposal in relation to the goals and objectives of the applicant institution and its probable impact upon ward or cottage practices and other patient improvement activities. This type of review necessitates consideration of such questions as:

1. The adequacy of the proposed plan, content, and method of training;

2. Staff qualifications, administrative support, and provisions for someone with responsibility for coordinating and directing the program;

3. The quality and continuity of instruction and the appropriateness of provisions for evaluation of the proposed training, including discriminating uses of outside resources, such as consultants and university instructional staff and facilities;

4. The resources available in the State agency responsible

for furthering the development of inservice training activities in the applicant institution.

I would like to conclude these remarks with the following suggestions to those interested in making application for an inservice training grant:

1. Read all the materials in the application kit. These materials and the Statement of Grant Award contain the answers to 90 percent of all the questions asked by applicant and grantee institutions.

2. Think in terms of a long-term, continuing program rather than a time-limited project. This year you may request program support for a 7 instead of a 5-year period, and such requests are renewable.

3. In any case, the proposal should be a meaningful and appropriate first or next step in the development of an inservice training program in the applicant institution.

4. Emphasize the behavioral rather than the physical aspects of patient care.

5. Provide for a meaningful use of available resources in (a) your own institution; (b) in your community; (c) in the State mental health agency and in other State agencies, such as colleges and universities; and (d) if needed, in out-of-State facilities.

6. Don't substitute Federal for State funds.

7. Have a friend, or better yet, an enemy, critically review the draft of your proposal.

8. Don't get discouraged! You can't lose anything in any effort you make to develop an inservice training program. Your secondary gains may yield as much or more than NIMH grant support.

AN ATTENDANT TRAINING PROGRAM IN THE STATE OF COLORADO

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Aware of the importance of highly qualified staff in administering care to the mentally retarded resident, the State Home and Training School at Wheat Ridge, Colorado, instituted several programs in 1962 which previously were not in existence. The beginning was in late 1961 when Wesley D. White was appointed Chief of the Colorado Division of Mental Retardation and Director of Ridge. Among these were:

1. Attendant Counselor Training Program, and
2. Supervisory Development Program.

The Attendant Counselor Training Program was a pre-service training program to prepare first-level attendants.

The Supervisory Development Program was a program for professional and sub-professional staff members charged with leadership responsibility.

I have been asked to speak briefly about the Attendant Counselor Training Program which was initiated at Ridge in July 1962. The aim of this program was to orient the new employee to his station of employment and to impart knowledges and to develop skills in preparation for the task of effectively providing treatment, care, training and rehabilitation for the mentally retarded individual. The minimum time established for completion of this training course was 10 weeks at 40 hours per week.

By 1963 the program was enriched and the minimum time for completion was increased to 6 months at 40 hours per week. In a period of 1 year, this reflects a change from 400 hours initially to 960 hours. The initial screening required average intelligence and high school graduation. Of 30 people who applied for the first program, 10 successfully passed the initial screening and were accepted, of this group 3 completed the 16 weeks of training.

Despite the fear expressed by many that raising standards would further deplete the graduation ratio, the School adopted a policy of stressing program excellence and relied upon the known job motivational strengths of achievement and work satisfaction to over-ride our original cause for pessimism.

The Attendant Counselor Training Program has since been expanded from an initial enrollment of 10 persons to a recent enrollment of 65 persons in a single class. Our staff for training was expanded from an original Senior Training Officer, Mrs. Lucille Bramley, to a staff of 9 persons--three of whom are academically prepared nurses.

As of the end of this month, a total of 240 first-level Nursing Attendants will have graduated from a 6-month Attendant Counselor Training Program. In addition, a second program was initiated in July 1964 which was designed to up-date those long-term employed attendants who had no previous opportunity for training. Both of these two attendant training programs were federally funded from the Department of Labor and the National Institute of Mental Health. Trainee salaries were supplied from the Budget of the State Home and Training School and on two separate occasions during this time the entire program was carried on the Ridge Budget. We regard our expenditure of nearly $200,000 per year in training as a prudent investment. As of this date, both training programs have resulted in the graduation of nearly 300 trained persons to offer more effective care to the mentally retarded within the School. Time does not permit my elaborating upon the curriculum of the program itself. However, I would like to very briefly review with you two of the procedures which we regard as being vital. These would be: (1) Establishing a permissive training atmosphere within the School which emphasizes the merits of a multi-disciplinary approach and is non-defensive about program limitations. By inculcating this attitude and atmosphere no one department has established "an empire" and a true setting for mutual educational growth has been established. Secondly, we have attempted to stress the importance of research and evaluation. Part of this stress resulted in an opinionnaire which was gicen to those attendants who completed the training program as well as to our training supervisors who taught the program.

As a result of the opinionnaire, changes were made. We have distributed copies of the opinionnaire for your review. We tried to make training closely identified with actual practice as much as possible. The frequency polygon which you see before you summarizes the result of a questionnaire which was prepared using a sampling of the topics of the training program. This sampling included topics taught in the classroom and in the work area. Attendants who had completed the training program were asked to rate the topics numerically; that is, excellent, which had a weight of 4; good, which had a weight of 3; fair, that had a weight of 2; and poor, that had a weight of 1. Furthermore, the attendants were asked to rank the quality of the program in four areas: hall relationship, topic content, presentation and practical applications. A total of 37 topics of the course content were selected through random sampling. Each topic was to be rated in each of the 4 areas, with a score between 1 and 4. The questionnaire was then given to 3 groups of 20 attendant personnel who had graduated from the training class and were ranked by their Home Living Supervisors as above average (Group A), average (Group B) and below average employees (Group C). A fourth group made up of 20 employees who had worked at Ridge many years without previous training but now were in the up-dating training class or had completed this class were also given the questionnaire and represented Group D. A fifth group was comprised of members of the Training Department. They were asked to evaluate the effectiveness of their own training not in theory but in practice. Group responses were averaged for each topic in all four areas and an over-all average was computed for each topic in each area.

Establishing a mean of 2.5 midpoint between ratings of Poor 1 and Excellent 4, the average for each group is plotted on the graph before you. The results were as follows: Group A - Above Average Attendants, mean of 2.72; Group 2 - Average Attendants, mean of 2.90; Group C - Below Average Attendants, mean of 2.86; Group D - Up-dating Class, mean of 3.20; Training Supervisors, a mean of 3.79.

It was interesting to observe that the group means for all four groups was 2.92, meaning that those people who had completed the training program evaluated its effectiveness as being well above the median. The range of mean scores did not exceed .71 in any area. Hence, the opinionnaire assisted us in improving our own program.

The future of Attendant Training at Ridge is assured in that we are convinced that the results justify the investment.

We are anticipating another revision upward from 6 months to 7 months in the near future. Entrance requirements will also be raised. The salary level has been approved and will result in a base raise of over $600 a year ($302 - $386 per month). In a few years the quality of care given has raised significantly. We feel this increase is directly proportional to the emphasis in and response from our Attendant Training Program.

The following will therefore represent an Introduction, Problem, Method, Results and a Summary. The enclosed "Topic Outlines and Methods of Teaching Related to Opinionnaire" indicate the changes that have been incorporated to date as a result of this last evaluation and opinionnaire.

AN EVALUATION OF THE IN-SERVICE TRAINING PROGRAM FOR ATTENDANTS

Introduction

The In-Service Training Department of the State Home and Training School at Wheat Ridge is responsible for the training and preparation of attendant trainee personnel for certified attendant status throughout the Home Living areas of the institution. Over 300 full-time positions for nursing attendants must be filled. The Attendant Training Program has been in existence since July, 1962, and has been partially financed through a grant from the Manpower Development and Training Act since August, 1963. Present training staff includes one Training Officer and four Junior Staff Assistants.

Training classes are 16 weeks in length, eight weeks in the classroom and eight weeks on a hall with from 40 to 60 trainees in each class., Subsequently, trainees are placed in the work setting for two months' joint evaluation before certification is recommended. After the six month program is successfully completed the attendant is given certified status by the Colorado Civil Service Commission.

Problem

Although the Training Program has been in existence since 1962, and under an MDTA grant since 1963, no complete evaluation of the program content has been made by a person outside the training staff. During the course of the program many changes have been implemented through joint consultation and/or referrals from other departments. An evaluation which would point out the strengths and weaknesses, correlations between classroom procedures, hall procedures, attendant interest, or lack of interest, in areas of instruction, topic content and presentation has not been attempted.

Method

A questionnaire was prepared using a sampling of the topics of the training program. This sampling included topics taught in the classroom and in the work area. Attendants were asked to rate the topics numerically, i.e., Excellent - 4; Good - 3; Fair - 2; Poor - 1; in the four areas listed following the topic:

Area I - Hall Relationship (what they felt hall duties were)
Area II - Topic Content
Area III - Presentation
Area IV - Practical Application

A total of 37 topics of course content were selected. Each topic was rated in each of the four areas above with a score between 1 and 4.

The questionnaire was given to three groups of attendant personnel (20 in each group) who had graduated from the training class and were working on the halls. The 60 attendants were selected and ranked by the Home Living supervisors as "above average, average, and below average" employees. The three groups, A, B, & C, were formed in this manner. A fourth group, made up of 20 employees in the Advanced Training Class and supervisors from the halls, was also given the questionnaire. Representatives in the Advanced Training Class had been given classroom theory of the attendant training program, but had not completed the 16-week program when the sampling was taken.

Members of the Training Department consisting of a Senior Training Officer, two Training Officers, and four Junior Staff Assistants were also given the questionnaire, not for use as an evaluative tool, but to provide a basis of correlation between the averages of the three groups who had graduated from the training class and the personnel who are responsible for training.

Group responses were averaged for each topic in all four areas and an overall average was computed for each topic and each area.

Results

Establishing a mean of 2.5, midpoint between ratings of Poor - 1 and Excellent - 4, the average for each group were plotted on a graph according to topic. The range of the averages above or below the median would indicate the need for close evaluation, with possible changes in curriculum by topic, teaching method, or presentation. The results were as follows:

Group Means (Includes all areas)

Group A (above average attendants)	2.72
Group B (average attendants)	2.90
Group C (below average attendants)	2.86
*Group D (advanced class and supervisors)	3.20

*Advanced Class had not completed course.

The group means were above the median with a range from 2.72 to 3.20, a difference of .48. The mean for all four groups is 2.92.

Summary and Recommendations

The validity of the results of the questionnaire given to the three groups of attendant personnel (graduated from the course), and the one group of advanced attendants (midway through the course), and supervisors (never exposed to the course) is indicated by the range of the mean scores of the four groups not exceeding .71 in any area. Of the 22 topics falling below the mean (2.50) in any of the four areas rated, one topic was rated down by all four groups in Area IV, Introduction to Mental Retardation, No. 32, four topics rated down by three groups:

GROUPS A, B, C

Topic	26	29	33	37
Area IV	3	3	2	3
Area III	2	1	1	3
Area II	1	1	1	3
Area I	-	1	2	2

Seven topics rated down by two groups:

Topic	7	9	10	16	22	25	28
Area IV	2	2	1	2	-	2	2
Area III	1	-	1	-	2	1	1
Area II	2	-	1	-	1	-	1
Area I	1	-	-	1	1	1	1

Ten topics rated down by only one group (A):

Topic	1	4	6	8	15	19	21	24	35	36
Area IV	1	1	1	1	1	1	1	1	1	1
Area III	1	-	1	1	1	-	1	-	1	-
Area II	-	1	-	1	-	-	-	-	1	-
Area I	-	-	-	-	1	-	-	-	1	-

Topics falling on or below the median (2.50)

Group A

	Topic	Area I.	Area II.	Area III.	Area IV.	Mean
1.	Guardianship	3.00	2.80	2.45	-2.50	2.69
4.	Training	3.00	2.45	2.7	2.50=	2.66
6.	Psych. Growth and Development	2.65	2.75	2.25	2.30	2.49
7.	Sociology	2.20	2.45	2.6	1.9	2.29
8.	Supportive Detail	2.85	2.50	2.50	2.40	2.56
9.	Counseling & Guidance	2.65	2.85	2.90	2.40	2.70
15.	Posture & Body Mech.	2.40	2.55	2.35	1.90	2.30
22.	Laundry	2.45	2.25	2.20	2.60	2.38
25.	Problem Solving	2.50	2.70	2.50	2.20	2.48
26.	Personality Influences	2.60	2.50	2.45	2.20	2.44
28.	Psychosocial and Cultural Considerations	2.20	2.15	2.05	1.85	2.06
29.	Adjustive Techniques	2.40	2.15	2.10	1.95	2.15
32.	Introduction	2.85	2.60	2.65	2.35	2.61
33.	Classifications of Etiologic Factors	2.45	2.50	2.45	2.00	2.35
35.	Special Problems	2.85	2.50	2.45	2.20	2.50
36.	Rehabilitation	2.55	2.55	2.55	2.05	2.43
37.	Trends	2.35	2.35	2.40	2.05	2.29

Topics falling on or below the median (2.50) - continued

Group B

	Topic	Area I.	Area II.	Area III.	Area IV.	Mean
7.	Sociology	2.60	2.40	2.45	2.30	2.44
10.	Public Relations	2.75	2.70	2.45	2.60	2.63
16.	Recreation	2.55	2.85	2.90	2.35	2.66
24.	Communication Skills	2.90	2.75	2.90	2.45	2.75
26.	Personality Influences	2.65	2.75	2.70	2.45	2.64
28.	Psychological and Social Considerations	2.40	2.55	2.45	2.35	2.44
29.	Adjustive Techniques	2.80	2.70	2.65	2.45	2.65
32.	Introduction	2.70	2.75	2.75	2.15	2.59
33.	Classification of Etiologic Factors	2.70	2.80	2.80	2.40	2.68
37.	Trends	2.50	2.45	2.45	2.10	2.38

Group C

	Topic	Area I.	Area II.	Area III.	Area IV.	Mean
9.	Counseling & Guidance	2.75	2.60	2.75	2.50	2.65
10.	Public Relations	2.55	2.49	2.55	2.40	2.50
16.	Recreation	2.50	2.65	2.75	2.25	2.54
19.	Toilet Hygiene	2.60	2.60	2.65	2.40	2.56
21.	Discipline	2.85	2.60	2.45	2.50	2.60
22.	Laundry	2.65	2.55	2.40	2.55	2.54
25.	Problem Solving	2.95	2.90	2.80	2.50	2.79

Group C - continued

	Topic	Area I.	Area II.	Area III.	Area IV.	Mean
26.	Personality Influences	2.65	2.60	2.50	2.40	2.54
29.	Adjustive Techniques	2.45	2.50	2.55	2.20	2.44
32.	Introduction	2.75	2.70	2.60	2.45	2.62
33.	Classification of Etiologic Factors	2.50	3.05	2.80	2.65	2.75
37.	Trends	2.55	2.50	2.70	-2.45	2.55

Group D

	Topic	Area I.	Area II.	Area III.	Area IV.	Mean
32.	Introduction	2.80	3.05	3.10	2.45	2.85

Topics by groups, below Median

Topic	Group
1.	A
4.	A
6.	A
7.	A, B
8.	A
9.	A, C
10.	B, C
15.	A

Topic	Group
16.	B, C,
19.	C
21.	C
22.	A, C
24.	B
25.	A, C
26.	A, B, C
28.	A, B
29.	A, B, C
32.	A, B, C, D.
33.	A, B, C
35.	A
36.	A
37.	A, B, C

Group Averages by Area

Group	I.	II.	III.	IV.	Av.
A.	2.81	2.76	2.74	2.55	2.72
B.	2.97	2.96	3.45	2.67	2.90
C.	2.91	2.93	2.85	2.74	2.86
D.	3.16	3.25	3.28	3.13	3.20
Mean	2.96	2.98	3.08	2.77	2.92
Range	.35	.49	.71	.58	.48

STATE HOME AND TRAINING SCHOOL
WHEAT RIDGE, COLORADO

IN-SERVICE TRAINING

TOPIC OUTLINES AND METHODS OF TEACHING, RELATED TO OPINIONNAIRE (TOPICS NUMBERED ACCORDING TO LISTING ON FORM.)

Topic I: GUARDIANSHIP

A. Topic Outline

1. Knowing each resident as an individual (by name) and to develop an awareness of special behavior patterns for the following purposes:
    - a. to give resident a feeling of well-being
    - b. handling of behavior problems
    - c. control of clothing problems
    - d. management of resident schedules
2. Awareness of location of resident for following reasons:
    - a. resident safety, protection and training
    - b. control of behavior
    - c. to maintain resident appointments and schedules
    - d. for escort services
3. Proper attire, hygiene and appearance:
    - a. bathing, shaving, shampooing, grooming
    - b. proper dressing
    - c. proper manners, habits, etc.
4. Control in specific situations, such as:
    - a. dayroom activities
    - b. playgound activities
    - c. dining room and feeding
    - d. toilet training
    - e. proper rest
5. Guidance by precept:
    - a. example and training
    - b. development of social skills as well as personal skills

B. Placement in Training Course

This material follows classroom lectures on:

1. Normal and Abnormal Growth and Development (Medical Doctor & Psychologist) (Approximately 10 hours)
2. How to Teach the Resident (Training Officer 4 hrs.)
3. Counseling and Guidance of Residents (Psy. & Voc. Rehab. - 4 hrs.)
4. Recreation - (Recreation Dir. - 2 hrs.)
5. Sociology - (Sociologist - 2 hrs.)
6. Discipline - (Psychologist - 2 hrs.)
7. Fundamental Skills - (Trainers - 40 hrs.)
8. Information Required of all Employees (Trainers - 2 hrs.)
9. Philosophy & Objectives of Ridge (Dir. - 2 hrs.)

C. Method of Teaching

Taught in small groups on the halls through the following methods:

1. Discussion groups concerning relationship of each topic to work situation. (1 trainer to 15 trainees)
2. Specific situations are pointed out and related to topic area
3. Assignments are made to trainees in escorting to appointments to dining room. Attending recreation with residents. Assignment to day room and other hall activities, assignment to bathing, dressing, toothbrushing, etc.

D. Changes Planned

More individual help by trainer to point out guardianship to trainee in working situations in hall area.

Topic 2: SAFETY

A. Topic Outline

1. First Aid - Immediate care for an injured resident until the nurse or doctor can get to the hall:

    a. how to care for a resident who is injured
    b. how to notify nurse or doctor
    c. prevention of accidents

2. Prevention - Making the trainee safety conscious:

    a. protecting the residents from injury
    b. proper ways of lifting residents to prevent injuries to trainees
    c. preventing spread of disease through proper hand washing, use of Wescodyne and care of soiled laundry
    d. cleaning up areas which might be fire or physical hazards (glass and broken objects in play areas)
    e. what to do in case of fire. (This cannot be carried out effectively because of lack of fire drills and planning on halls by older personnel)
    f. location of fire extinguishers and how to use them. Location of fire hoses.
    g. proper food handling to prevent contamination and growth of bacteria which cause food poisoning. Proper personal hygiene when handling food
    h. traffic regulations

B. Placement in Training Course

Follows:
1. Standard First Aid Course
2. Fundamental Skills
3. Information Required of All Employees

C. Method of Teaching

a. small group discussions about problems they have observed at Ridge
b. hazards are pointed out on halls and supervisors work with trainees to correct any that can be corrected.
c. supervisors demonstrate how to serve food
d. supervisors set example for trainees in personal cleanliness
e. trainees are assigned to help serve food
f. driving rules are re-emphasized
g. protective measures for children in living area are pointed out, i.e., crib sides always up.

D. Changes Planned

More individual help by Training Supervisor in pointing out to trainee in working area the concepts of being safety conscious.

Topic 3: PERSONAL HYGIENE

A. Topic Outline (All items listed herein come under the same topic outline, placement, method of teaching, etc.: Guardinaship #1, Safety #2, Bedmaking #3, Bathing #12, Dressing #14, Posture #15, Toilet Hygiene #19)

1. To promote positive habits of personal hygiene, to promote health, comfort and well-being, and a healthful living environment. To create an inside society similar to the outside society.

2. Procedures included: Grooming, shaving, shampooing, bathing, tooth brushing, toilet training, dining and feeding, housekeeping, dressing, bedmaking.

B. Placement in Training Course

Procedures of fundamental skills, Philosophy and Goals of Ridge, Information Required of All Employees, Posture, Body Mechanics and Positioning are formal classroom lectures which precede this instruction (8 hours).

C. Method of Teaching

Each subject is taught procedurally to each trainee in the hall area by the training supervisor. There is a demonstration by trainer, return demonstration (by each trainee). There is a return demonstration by the trainee supervised by the supervisor until the practice is considered proper and safe.

D. Changes Planned

None

Topic 4: TRAINING

A. Topic Outline

1. Each child is an individual and they cannot learn at the same rate.
2. Mentally Retarded learn through repetition
3. If a child can learn nothing more than dressing

and feeding himself, he is making progress and will be a happier child.

4. Promoting self-help among the residents is emphasized during entire training course.
5. Supervisors help trainees learn what each child can do and what each child can learn.
6. Working residents should be praised when they do a good job in work areas. Working with residents sometimes produces better results than telling a resident what to do.

B. Placement in Training Course

Follows classroom lectures on:

1. Teaching-Learning
2. Counseling and Guidance
3. Philosophy and Objectives of Ridge

And is stressed throughout the entire training course.

C. Method of Teaching

Taught on the halls by:

a. Supervisors demonstrating by teaching residents
b. Point out specific children, tell what they could learn.

D. Changes Planned

None

Topic 5: HOUSEKEEPING

A. Topic Outline

The purpose of creating a healthful living environment is explained. Definition and reasons for biological housekeeping in an institution, such as Ridge. How to carry out proper measures to obtain this type of housekeeping.

B. Placement in Training Course

This is given early in the training course in order that the trainee may better understand his duties as housekeeper.

C. Method of Teaching

1. Lecture to entire class by Medical Technologist (Bacteriological Housekeeping - 2 hours)
2. Group Discussion in Groups of 16 Trainees by training supervisor, use typed procedure from Procedure Book.
3. Demonstration of procedures by training supervisors, return demonstration by each trainee. This is done in small group of 6 trainees in working area.

D. Changes Planned

Movie on Biological Housekeeping followed by group discussion of 15 trainees per training supervisor

Topic 6: PSYCHOLOGICAL GROWTH AND DEVELOPMENT

(See Topic 27: GROWTH AND DEVELOPMENT)

Topic 7: SOCIOLOGY

A. Topic Outline

1. To develop skills in working with people of various backgrounds - understanding interpersonal relationships in the working situation. To transfer this knowledge to the work with mentally retarded residents.

2. How to deal with people in the actual work situation. To understand the multiple interpersonal relationships existing in a work setting. How changing personnel on a hall affects working relationships. Why people resist change in their work situation or environment.

3. What type of groups could accomplish the most and why.

B. Placement in Training Course

This material follows classroom lectures, Problem Solving, Public Relations, Interpersonal Relationships, Communication Skills, Personality, Influences and psychosocial and Cultural Considerations.

C. Method of Teaching

Sociology is taught in small groups on the halls through the following methods:

1. Small groups of 6 trainees by training supervisors.
2. Bring out how to get along with people who differ in race, religion, and culture and social status.
3. Explain to trainees that residents on the halls will become unruly when exposed to new people in their environment and after a couple of days will settle down to routine again.

D. Changes Planned

Planned Hall conferences to demonstrate how this material is applicable to resident and how it can be used by the trainee.

Topic 8: SUPPORTIVE DETAIL

A. Topic Outline

1. Reporting and Recording as follows:
    a. changes of behavior pattern of residents
    b. changes in health status of resident
    c. recording of seizures (as required)
    d. recording temperatures of residents
    e. reporting shortages of all types of items used in the care of residents and halls.
2. Use of Logs on Hall Areas:
    a. reporting for work as scheduled
    b. reading of log from previous shift
    c. keeping head count of hall
    d. signing of daily hall report
    e. writing all pertinent information in the logs
    f. making entry of any and all errors (especially medications)
    g. reporting to nurse on duty in case of medication error.
3. Necessity to adjust to emergencies:
    a. work on shift
    b. work on hall
    c. changes of day off schedule

4. Fulfillment of requests from other departments

B. Placement in Training Course

This topic follows class lectures covering the following:

1. Medication procedures
2. Sociology
3. Study of Job Specifications
4. Goals of Ridge
5. Teaching-Learning
6. Problem Solving
7. Communication Skills
8. Interdepartmental functions and relationships

C. Methods of Teaching

Supportive Detail is taught and reviewed by training supervisors from actual hall experience.

1. discussion groups in review of lectures and films.
2. specific situations picked from films and discussed with group.
3. situations acted out in groups following preparation of material
4. actual hall application in the hall setting as trainees are assigned to the various halls:
    a. log reading
    b. daily hall report
    c. seizure reports
    d. behavior reports
    e. referrals:
        1. medical
        2. psychological
        3. social service
        4. school dept.
        5. recreation
        6. vocational rehab.
5. Awareness of resident schedules
    a. school
    b. music
    c. psychology
    d. medical
    e. dental
    f. recreational

D. Changes Planned

Emphasis will be made demonstrating each item listed above.

Topic 9: COUNSELING AND GUIDANCE

A. Topic Outline

Points out different types of behavior problems:

1. Hyperactive, sex problems, masturbation, rocking child, aggressive, temper tantrums
2. Methods of handling these problems on the halls
3. How to give guidance to residents whenever needed in: personal care, work areas, and any immediate need.
4. Importance of knowing each child as an individual with individual needs and problems:
   a. encourage resident to talk freely
   b. keep what resident tells you confidential, if you cannot help a resident with a problem, talk confidently to the person in charge of hall.
5. When to refer resident to Psychology Department

B. Placement in Course

This material follows classroom lectures on:

1. Behavior and discipline
2. Counseling & Guidance
3. Normal Growth & Development

C. Method of Teaching

1. Point out specific behavior problems on halls and demonstrate how to handle them.
2. Assignment to hall areas

D. Changes Planned

This material has been outlined for showing direct application on the hall and will be through small group conferences.

Topic 10: PUBLIC RELATIONS

A. Topic Outline

To perform as host or hostess: functions to incoming groups on the halls, also we stress their role of public relations agent for Ridge in the community setting.

B. Placement in Course

In the program, this follows lecture on parent/attendant relationship and training department lectures on public relations.

C. Method of Teaching

1. Lecture on parent/attendant/child relationships
2. Trainers discuss this topic with entire class
3. Trainers lecture and show films on public relations and interpersonal relationships.
4. Small discussion groups of 15 trainees
    a. to apply information given to halls through example and demonstration
    b. to stress employee's role to the public, how to behave in public, people judge Ridge by people they employ, and how these people act in work situation, and how they act outside of work situation.
    c. write a situation of public relations they have experienced in other employments.

D. Changes Planned

Emphasis will be given to better methods of presentation and specific areas will be demonstrated.

Topic 11: INTERPERSONAL RELATIONS

A. Topic Outline

1. Reporting for duty as scheduled
2. Respect for rights of others
3. Maintain good working relations

4. Cooperation with other employees
5. Care of supplies and equipment
6. Cooperation techniques
7. Self understanding

B. Placement in Course

Presented early in course to enable trainee in understanding how to get along in working with residents and co-workers.

C. Method of Teaching

1. Have lecture on Interpersonal Relationships; self understanding & sociology.
2. Review of lecture in small groups, discussing the use of materials in lecture when applied to hall situation.
3. Handling of specific situations as outlined through small group work.
4. Practical use of material on a hall situation. Trainers act as liaison between trainees and hall personnel.

D. Changes Planned:

None

Topic 12: BATHING

(Refer to Topic #3) Personal Hygiene

Topic 13: BEDMAKING

(Refer to Topic #3) Personal Hygiene

Topic 14: DRESSING

(Refer to Topic #3) Personal Hygiene

Topic 15: POSTURE AND BODY MECHANICS

A. Topic Outline

To promote the use of proper muscles and body parts, both employee and resident, for promotion of safety in a work setting.

B. Placement in Course

Following lectures on anatomy, physiology of muscular skeletal syatems.

C. Method of Teaching

1. Lecture by Training Officer (2 hours)
2. Demonstration by trainers (classroom)
3. Return demonstration by trainees
    a. Lifting of objects used on the halls (buckets of water, etc.)
    b. proper use of mops to avoid overstrain
    c. method of lifting residents (chair to bed) (bed to chair) (floor to chair or bed)

D. Changes Planned

Individually supervised demonstration will be emphasized.

Topic 16: RECREATION

A. Topic Outline

1. A child who is busy with some kind of activity is seldom a behavior problem.
2. Importance of planning activities to fit the mental age of the child.
3. How to interest some of the children who are withdrawn in group activities.
4. Some activities which are suitable for each hall.
5. Safety factors involved in recreation:
    a. small objects which can be put in child's mouth
    b. sharp objects
    c. indoor activities which are too rough.

B. Placement in Course

This material follows class lectures on Normal and Abnormal Growth and Development; Objectives of Ridge; Behaviors; also Recreational Therapy.

C. Method of Teaching

1. Trainers participate with trainees in hall activities with residents.

2. Assignments to day room areas and playground areas and to participate in activities planned by Recreation Dept. (bus rides, ball games, picnics, etc.)
3. Two hours of lecture by Recreation Dept.

D. Changes Planned

Emphasis as a part of attendant's duty and demonstration of "how" on the hall.

Topic 17: SEIZURES

A. Topic Outline

Types, possible causes, treatment and immediate care of seizure patient. How to observe a resident during a seizure. How to fill out seizure reports.

B. Placement in Course

This is presented in the part of the course covering diagnostic classification. This follows immediately after the lectures on Normal Growth and Development of the child and medical aspects of Mental Retardation.

C. Method of Teaching

1. Convulsive Disorders (2 hours)
2. Movie
3. Small group discussions of 15 trainees by training supervisor
4. Application of classroom knowledge pointed out by training supervisor
5. Trainee, assisted by training supervisor, makes out seizure reports.

D. Changes Planned

Hall conferences in each area to discuss types of seizures observed on particular hall area, and to stress care of resident during a seizure

Topic 18: TREATMENTS

A. Topic Outline

Types of treatments most frequently seen at Ridge and reasons for each as well as how to carry out each treatment. During hall assignment, trainees are asked to do necessary treatments on residents:

1. Hot and cold packs
2. Warm soaks
3. Caring for minor wounds
4. Enemas & suppositories
5. Sponge baths
6. Taking a rectal temperature

B. Placement in Course

Follows lectures on anatomy and physiology and lectures on symptoms commonly observed in children.

1. 6 hours of lecture and demonstration by R. N.
2. Each trainee is closely supervised by trainer until they know the procedure well enough to do it without supervision.

Topic 19: TOILET HYGIENE

(refer to Topic #3) Personal Hygiene

Topic 20: BEHAVIORS

A. Topic Outline

To acquire an understanding of types of behaviors experienced on the hall areas and to develop the proper methods of handling these behaviors. An understanding of the reasons for these bahaviors in the residents.

B. Placement in Training Course

Follows lectures on behavior problems and discipline.

C. Method of Teaching

1. Two-hour lecture on behavior problems in Mental Retardation.
2. One-hour discussion on "Information Required of All Employees".
3. Demonstrate on actual hall experience, trainer goes on hall where trainees are assigned. Observes trainee using knowledge gained and giving support to trainee when and where it is needed.

Trainee feels more secure in handling behavior problems, they are given examples of solutions that have worked many times, this is a good basic for handling unusual problems of behavior as they arise on the home living area. It is stressed, never to ignore a behavior, they are also taught to search out facts bringing on behavior so they will have a better understanding of why the resident behaves as he does.

4. Role play in classroom demonstrating various types of behavior and methods of handling.

D. Changes Planned

Hall conferences on hall area to discuss behavior problems on particular area and possible methods of handling problems.

Topic 21: DISCIPLINE

A. Topic Outline

1. Methods of discipline used and approved by institution.
    - a. no corporal punishment can be used
    - b. withholding of privileges
    - c. necessity for each method of punishment to be a learning experience for the resident
    - d. the use of referrals to other departments for assistance.
    - e. proper use of quiet rooms and the necessary forms in this connection
    - f. counseling in small groups of residents or on an individual basis as indicated.
2. Use of restraints on residents:
    - a. under doctor's orders only
    - b. use restraints only in a careful and humane manner where harm may come to other resident or employee.

B. Placement in Training Course

Follows:
1. Recreation lecture

2. Vocational Rehabilitation Lecture
3. "Now They Are Grown" - Trainers - 1 hour
4. Lecture & Demonstration Growth & Development - (20 hours)
5. Lecture: Special Hall Recreation
6. Lectures on Occupational Therapy and its use in control of behaviors.

C. Method of Teaching

1. Behavior Problems and Discussions (2 hours)
2. Explanation of handling female residents to male trainees by trainer - 1 hour.
3. Practical Use of Hall Situations during hall rotations (under supervision)
4. Special hall assignment on activities for residents - 2 hours.
5. Small discussion groups of 15 trainees by training supervisor discussing from "Information Required of All Employees".

D. Changes Planned

None

Topic 22: LAUNDRY

A. Topic Outline

Emphasis is placed on a uniform method of handling clean and solied materials and proper marking, repair and disposal on the hall area.

- a. clean laundry is placed in proper storage (sorted)
- b. materials in need of repair are sent to sewing room.
- c. soiled laundry is placed in hamper
- d. personnel is instructed concerning transmission of disease, isolation technique and personal hygiene

B. Placement in Training Course

Presented early in the course with "Fundamental Skills".

C. Method of Teaching

This subject is taught entirely by training supervisor demonstration on the hall area to groups of 4 trainees. Supervised practice follows each return demonstration.

D. Changes Planned

This material will be presented formally in the classroom; subsequently, it will be demonstrated on hall. Isolation Procedure has been developed and will become a part of teaching program.

Topic 23: GENERAL INFORMATION

A. Topic Outline

This includes history of Ridge; policies of Ridge, as related to hours of work, etc. Administration and Organizational Patterns discussed as shown on chart. Services of the following explained: administrative, business, personnel, clinical.

What is meant by types of commitments and rights of residents. Duties of the trainee and the attendant explained from study of job specifications.

Benefits of employee organizations and dates of meetings held.

Philosophy and Objectives of Ridge.

Personal adjustment and responsibility of the trainees and how training department will help in this and how to obtain help from training supervisor in trouble areas or in doubtful areas.

B. Placement in Training Course

First week of class

C. Method of Teaching

a. Lectures to Entire Class
b. Group Discussion in groups of 15 trainees with training supervisor.

D. Changes Planned

a. more small group discussions with encouragement for everyone to talk.

b. tours in small groups, led by training supervisor rather than by Volunteer Services.
c. discussion period after leaving hall area.

Topic 24: COMMUNICATION SKILLS

A. Topic Outline

Points out how communication skills aid in working with employees, residents and with members of community. How communication lines are broken and why, what is feedback and its meaning. How to successfully communicate up and down channels in an institution.

B. Placement in Training Course

Following interdepartmental and interpersonal relationships, problem solving, and teaching responsibility.

C. Method of Teaching

a. Lecture on theory of communication to entire class - 2 hours.
b. Small discussion and role playing groups of 6 persons - 2 hours.
c. Review of lecture in groups of 15 trainees by training supervisor as it applies to work situations.
d. Projects assigned individually to trainees for evaluation while they are working in the hall areas.

D. Changes Planned

Review of lecture in groups of 15 trainees by training supervisors with each supervisor using same typed lesson plan and encouragement of group discussion among trainees; emphasis placed on individual projects among trainees' social gatherings,work setting, etc. with definite follow through by the training department.

Topic 25: PROBLEM SOLVING

A. Topic Outline

Symptoms of a problem, how to identify a problem, how to gather information for problem solving, and how to apply methods for solving a problem.

B. Placement in Training course

Second month of course

C. Method of Teaching

a. Lecture to entire class by training officer (2 hours)
b. Demonstration to entire class by groups of trainees on solving problems in working situations (by training supervisors)
c. A written report handed in by each trainee on a problem which they have identified existing either in class or hall situation. How problem was handled and other methods by which it might have been handled.

D. Changes Planned

a. Review of lecture in groups of 15 trainees with group discussion and role play. This will follow the formal theory presentation of 2 hours.
b. In groups of 15 trainees discuss some written problems handed in by the class, i.e., taken from weekly reports. Use group process in actually solving a problem with trainer serving as a resource.
c. During hall assignment, the trainer will assist the trainee in putting "on-the-spot" problems which arise into the problem solving frame work and work it through.

Topic 26: PERSONALITY INFLUENCES

A. Topic Outline

1. How heredity and environment influence personality
2. How the basic, biological, psychological and sociological needs influence personality.

B. Placement in Training Course

During lecture of Normal Growth and Development

C. Method of Teaching

1. Lecture to entire class (Emotional and Psychological Growth & Development)
2. Lecture Organic physical development - 1 hr.
3. Discussion of theory in groups of 15 trainees with training supervisors.
4. Movies to entire class on this specific topic.

D. Changes Planned

1. Discussion in groups of 15 trainees by training supervisors and each supervisor having the same lesson plan emphasizing the identical points.
2. Hall conferences emphasizing this topic in hall area by training supervisor, specific application to situations in the hall area. Present cases to demonstrate such an environmental deprivation

Topic 27: PSYCHOLOGICAL GROWTH AND DEVELOPMENT

A. Topic Outline

To acquire an understanding of physical, mental, emotional and spiritual growth and development of the human being:

a. to understand behaviors of normal children
b. consider their mental and their chronological age
c. to understand a child should achieve at a certain age and what behaviors are ususal, etc.
d. to understand the M.R. child, his achievements, limitations and behaviors.

B. Placement in Training Course

This material follows classroom lectures, counseling and guidance, problem solving, personality influences, care dependent on levels of retardation.

C. Method of Teaching

Growth and Development is taught in the classroom and on the halls through the following methods;

1. Bring all ages of normal children into the class room to let class observe normal behavior.

2. Bring all ages of residents into the class room so trainees may observe and compare behavior.
3. Trainers point out specific examples and situation in work setting.
4. Trainers make known to trainees on hall rotations, what age level they are dealing with.
5. Lectures to entire class:
    a. physical growth and development of child from birth to about 17 years of age - Medical Doctor - 6 hours.
    b. psychological growth (same ages) by Psychologist - 6 hours
    c. spiritual growth and development (same ages) - Minister.

D. Changes Planned

Hall conferences on hall area to emphasize this topic in hall area by training supervisor.

Topic 28: PSYCHOSOCIAL AND CULTURAL CONSIDERATIONS

A. Topic Outline

Discussion of one's role in the family, community, and work situation. How various cultures in our communities differ and how these influence our behavior and way of living.

B. Placement in Training Course

Early part of Program

C. Method of Teaching

1. Lecture to entire class by Sociologist - 4 hours.
2. Discussion in groups of 15 trainees on how to apply lecture material to working situations by training supervisors.

D. Changes Planned:

1. Encourage more group discussion in groups of 15 persons as how to apply class material to working situations.
2. Discussion of actual situations among employees and residents, attempting to put this information into practice.

Topic 29: ADJUSTIVE TECHNIQUES

A. Topic Outline

1. Definition of anxiety, tension, defense mechanisms.
2. How any individual operates under stress situations.
3. Methods by which the M.R. adjusts to the situation and how he relieves himself of the particular situation.

B. Placement in Training Course

First month of course.

C. Method of Teaching

1. Lecture to entire class by Psychologist - 2 hours.
2. Small group discussion groups of 15 trainees as to hall application. Examples of behaviors from actual hall situations.

D. Changes Planned

1. Hall conferences on the areas discussing actual situations on particular hall where conference is being held and where trainee is presently working with emphasis on what part the trainee can play in dealing constructively with this situation.
2. Promote self evaluation in stress situations.

Topic 30: PREVENTION AND SAFETY

(Refer to Topic #2) Safety

Topic 31: PHYSICAL CARE

A. Topic Outline

1. Overlap of personal hygiene, housekeeping procedures, bedmaking, observing, recording, laundry, supplies, etc.
2. Anatomy and physiology of the following body systems: Neuromuscular, skeletal, digestive, circulatory, integumentary and respiratory tract.

   Discussed in terms which the trainee can understand which improves trainee comprehension of why certain types of care is necessary, i.e., proper exercise or positioning for adequate growth of skeletal syatem. Application of neuromuscular and skeletal systems to safety in proper lifting and body mechanics. How anatomy and physiology of digestive tract correlates with lectures on nutrition and food handling. Application to spread and control diseases of digestive tract. Application to giving of enemas. The circulatory system as it applies to checking pulse. Safety in checking hemorrage. How disease and excitement and drugs affect circulatory system. Application of proper skin care and care of bed sores, is given in anatomy and physiology of integumentary system. Prevention and control of infections by proper skin care.

Discussion of skin disease commonly seen in care of children and how to apply this to care of residents at Ridge.

Anatomy and physiology of the respiratory tract is to point out specific respiratory diseases in children and how the attendant can help control spread of these diseases. The importance of reporting respiratory diseases to the R.N. in the hall area. How the attendant can protect himself from common respiratory diseases and how to care for himself if he does contact respiratory infection.

B. Placement in Training Course

Early in the course with Fundamental Skills and Hall Procedures.

C. Method of Teaching

Lecture and demonstration.

D. Changes Planned

None

Topic 32: CLASSIFICATION OF ETIOLOGICAL FACTORS

A. Topic Outline

1. Names of various types of M.R. and possible causes for some types of M.R.

2. Hereditary factors, environmental factors emphasized.
3. Types of M.R. which may be prevented.
4. Physical characteristics and possible behaviors of various types of M.R.

B. Placement in Training Course

Immediately following lectures on Normal Growth and Development.

C. Method of Teaching

1. Lecture to entire class by Medical Doctors - (8 hours)
2. Small group discussions with 15 trainees by training supervisors.
3. Training Supervisors point out types of residents in hall area.

D. Changes Planned

Hall conferences in hall area by training supervisors emphasizing attendant duty in various cases.

Topic 34: CARE-DEPENDENT ON LEVELS OF RETARDATION

A. Topic Outline

a. Causes: The causes of M. R. which are discussed in class relate to biochemical causes, causes at birth, and postnatal causes. Examples of various types of these are brought to the class room for the trainee to observe the residents.
b. Behavior control is explained by discussing various types of behaviors seen in different levels of the M.R. Reasons for the types of behavior and how to manage the situations which arise.
c. Treatment-Medications and diets which are used in certain types of M.R.; promotion of activity of positioning in bed according to ability of M.R.
d. Training of the M.R. in the areas of socialization, self-help, supervision in personal care are given as an effort to accomplish one of the goals of Ridge which is to make the

inside society as near like the outside society as possible. The social graces and proper etiquette are stressed, especially that of the attendant being an example.

e. The educable and trainable resident are discussed and residents from the school visit the classroom to demonstrate their abilities.

f. Speech Dept.--emphasis on how the attendant can help the child who needs assistance in his speech. Sound responses if words are not formed, word response if words can be used by resident. Communication on the resident's level.

g. Music Therapy. Effects of music on the individual and reasons for residents attending music therapy. This medium as a therapeutic measure in total care.

h. Recreation--Types of recreation for different levels of M.R., reasons for recreation and how to use it. This includes emphasis on creativity development within the trainee in cases where the resident is confined.

i. Psychological and Physical Safety for the M.R. dependent on level.

B. Placement in Training Course

Throughout the course.

C. Method of Teaching

a. Causes of M.R. - Lecture - 8 hours, Medical Doctors (6) - State Consultant M.R. (2) Environmental, Pre, Para, and postnatal.

b. Behavior Control - Lecture - Psychologist (2 hours)

c. Treatments - Lecture - Discussion - Medical Technician 5 hours, Medical Doctors

d. Socialization - Discussion - 15 trainees to training supervisor.

e. Training - Lecture - School Principal - 1 hr. School Goals in M.R. Demonstration by residents, Teachers - 1 hr.

f. Speech - Lecture and Demonstration by Speech Therapist - 4 hours.

g. Music Therapy - Lecture and Demonstration - Music Therapist - 2 hours.

h. Recreation - Lecture and Demonstration - Recreation Director - 2 hours and Assistant - 2 hours.

i. Each of these lectures followed by group discussion of 15 trainees and training supervisors.
j. Trainees are assigned to participate in recreation situations with the residents.

D. Changes Planned

Hall conferences in hall area following lectures. Conferences held by training supervisors. Emphasis on trainee using mere individual creativity in working with less active residents in hall areas.

Topic 35: SPECIAL PROBLEMS

A. Topic Outline

Behavior problems are discussed according to cause and how to find cause of a resident's behavior and how to deal with the behavior problem.

Methods of motivating the residents to accomplish tasks, also self-motivation. How to cope with residents with physical defects. Reasons for their types of behavior and what to expect of them. How we can be of the most help to them.

Convulsive Disorders: Type of seizures, those most commonly seen at Ridge. How to care for seizure patient and how to observe a seizure. Possible causes of seizures--medications frequently used for control of seizures and reasons for drugs.

Cerebral Palsy: Definition of C.P. How C.P. children are cared for physically and mentally, and rehabilitation of C.P. individual.

B. Placement in Training Course

Last month of course.

C. Method of Teaching

a. Lectures by Psychologists and Medical Doctors.
b. Field trips to C.P. Center.
c. Movies
d. Discussion groups of 15 trainees with training supervisors.
e. Individual teaching of trainee by training supervisor on hall area.

D. Changes Planned

Hall conferences to correlate hall situations and class room lectures.

Topic 36: REHABILITATION

A. Topic Outline

Objective is one of the rules of Ridge: That no one should remain at Ridge who can function in the community.

The topics of selection, techniques and evaluation are Vocational Rehabilitation Staff.

B. Placement in Training Course

Third month of course.

C. Method of Teaching

Lecture by Director of Vocational Rehabilitation - 2 hours.

Tour of Vocational Rehabilitation and Work areas in groups of 15 trainees.

Discussion of material, purposes, and how attendant can participate in promotion of rehabilitation of the resident.

D. Changes Planned

None

Topic 37: TRENDS

A. Topic Outline

Development of organization - purpose and locations of organizations. Who is eligible for membership. Public relations of the organizations.

B. Placement in Training Course

At the end of course

C. Method of Teaching

Parent Groups: How and Why Organized. The need for such groups and how the attendant can help in these groups. Functions of these groups.

Home Care and Special Education: The need explained, and how parents obtain special education for the M. R. or handicapped.

Types of Community Clinics and Facilities: Locations, reasons for such, types of functions, who is eligible for care in the centers. The M.R. in schools, churches, scouts, etc.

Vocational Training: Types, how to obtain this help, and need for such.

Community Services: Types and purposes of service.

Publicity: Types - How to produce good publicity for your friends. Proper education of the public toward M.R. Introducing modern concepts of M.R. and banishing of old sterotyped ideas.

Research: Purpose of research - types done at Ridge. Plans for future research.

General Trends:

General trends in the field of M.R. Those emphasized in M.R. - A National Plan for a National Problem. Trends toward community and institutional interaction in M.R. Interdisciplinary interaction in M.R., etc.

D. Changes Planned

Emphasis on each area listed plus more visitation to groups.

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